Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No.2 1. Decedent's Name (First, Middle, Last) 2. Date of Death .Month **Physician** 2011 /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🕅 F Days 217-74-1898 **Director** 10/10/1955 WASHINGTON D.C Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show 1 XYes 2 ☐ No Directo 28a-f QUEEN ANNE'S MARYLAND CENTREVILLE 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? Items 23a or must be 21617 USA 429 WATSON ROAD Funeral Was Decedent Ever in U.S. Armed Forces?
 1 ☐ Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 ☐ Yes 2 ☑
If Yes, Give
Year or Dates: 0. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify \$ 3 Widowed 4 Divorced WHITE "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene.

is marked other than "natural aumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) COSMETOLOGY BEAUTICIAN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ည EDWARD F. O'CONNELL SHARON WHITLEY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 JIM O'CONNELL/BROTHER 3511 WILLOW ROAD, DOVER, PA 17315 item 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of F Important: If ite any injury or of once. CHESAPEAKE CREMATION 07/09/2011 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) STEVENSVILLE, MD 21. Signature of Euroral Service Licensee 22. Name and Address of Facility 22. Name and Address of Facility LASTING HELFENBEIN & NEWNAM CREP. A. 814 BESTGATE ROAD, 23a. Per 1. Enter the disease, or composition of the composition of th cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate one cause on each line Immediate Cause (Final Physician POREMIC respiratory disease or condition resulting in death) Medical (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Metastatic Unch carcinoma physician and as the burial-tran resulting in death) Last Due to (or as a consequence of Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Tetal death Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the at ald be detached f 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown 2 No 3 Probably Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has bilirector, page 2 2 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Inpatient examiner? Other: 4 \sum Nursing Home 2 1 No 1 Tes 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) မ funeral Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Yes 2 No 2 Accident by the

To the Hospital or Attending Physician; The law requires that the death certificate be executed 24 hours within 24 hor To the Fune completely fi

5

Registrar

Medical

ristine State

3 Suicide

29a. Certifier (check only

one)

4 - Homicide

MD

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Could not be

determined

600 North Wolfe St, Baltimore, MD, 21287

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

31. Date filed (Mor

29b. Signature and title of certifier

32 Registrar's Signatur

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		4	For State	State of Maryland	/ Depa	rtment of H	lealth and	Mental Hy	giene 20		24002
			Registrar 1. Decedent's Name (First, Middle, Last,		Cert	meate or E	Catil	2. Date of De	ath		3. Time of Death
			Charles Edward	Parmley				July	Day 9	2011	10:45 A ^M
			4a. Facility Name (if not institution, give s			4b. City, Town, or	Location of Deat		4c. County		
and de			Morningside Hou			Waldo				Les Co	
	Funeral		5. Social Security Number 6. Sec	7. Age (In yrs. last I	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Bir (Month, Da March	th y, Year) 1929	9. Birthpla Country Alaba	ce (State or Foreign
			416-32-8302 Line State of December 1	. 02				march c	1929	ALAUC	inia
	shov dat	to	10a. State 10b. County	10c. City, To						100	d. Inside City Limits
	Mary 28a-1 otifie	irec	Md Prince G	eorge's Te	emple	Hills					1 X Yes 2 No
	th the 3a or t be n	ral D	10e. Street and Number			10f. Zip Code 20748			10g. Citizen of US.		y?
	ath wi	mel	7209 Waldron Ave	12. Was Decedent Ever in U.S.	13. W	as Decedent of Hi	spanic Origin? (S	pecify Yes or No-		ce - America	Indian,
9	or ite		1 ☐ Never Married 2 🔀 Married	Armed Forces? 1 Yes 2 □ No		Yes, specify Cuba		to Rican, etc.)		ck, White, et	
933	urs aff :ural", al Exa	ted	3 Widowed 4 Divorced	Year or Dates. 1930			es 2 🗷 No Specify:			Whit	
<u>5</u> -	72 hoi r" nat	nple	15. Decedent's Ed (Specify only highest grad		(Give ki	ent's Usual Occupa ind of work done a NOT use retired)		rking	16b. Kind of E	usiness Indu	stry
75	vithin iene.	Sol	Elementary/Seconday (0-12)	College (1-4 or 5+)		lane Mecl	nanic		US Ai	r Forc	e
٥	filed vall Hyg		17. Father's Name (First, Middle, Last)	· · · · · · · · · · · · · · · · · · ·				me (First, Middle,	Maiden Surnam	e)	
ylaı	ld be Menta rarked artic e	욘	William Parmley				Lena	Lockhea	rt		
Nar	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit completed filled in by the funeral director. After this must be notified at completed filled in by the funeral director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit completed filled in by the funeral director. After this certificate has been signed by the attending physician and complete filled in by the funeral director. After this certificate has been signed by the attending physician and complete filled in by the funeral director. After this certificate has been signed by the attending physician and complete filled in by the funeral director. After this certificate has been signed by the attending physician and complete filled in by the funeral director. After this certificate has been signed by the attending physician and complete filled in by the funeral director. After this certificate has been signed by the attending physician and complete filled in by the funeral director. After this certificate has been signed by the attending physician and complete filled in by the funeral director. After this certificate has been signed by the attending physician and complete filled in by the funeral director. After this certificate has been signed by the attending physician and complete filled in by the funeral director. After this certificate has been signed by the attending physician and complete filled in the funeral director. After the funeral director and complete filled in the funeral director. After the funeral director and complete filled in the funeral director and complete filled in the funeral director and complete filled in the funeral director and complete filled		19a. Informant's Name/Relationship (Typ			g Address (Street a		_		State, Zip Co 20748	1
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nor	age 1 ent of nt: If ii y or o		1 🛣 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State ceme	etery, crem	atory or other place oln Cemet			Brentwo		. 1
alt:	mit. Pa partme portan / injur.		21. Signature of Funeral Service License			Name and Addres					
Ď	Deer and	- 10	Diete Macus	/	34	01 Blade	nsburg R	d Brent	wood, M	d 207	22
1			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	lications that caused the death. Le cause on each line. a	553	r the mode of dying	g, such as cardia	Live,	rest,	1	Approximate nterval Between Onset and Death
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		ner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequent	ce of):						
	outed nd ransit	cami	Cause (Disease or iinjury that initiated events	c							
	e exe	alE	resulting in death) Last	Due to (or as a consequent	ce ot):						
760	cate b physi	edic		d							
89	certifi inding use as	Ju/M	23b. Was decedent pregnant	23c. If yes, outcome of pregnancy		Ectopic pregnance	N/		23d. D	ate of deliver	у
. Box 687	ne death y the atte ched for	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time of dear		Other (specify)	·y		M	onth [Day Year
P.O.	that the ned by e deta	by P	Part II. Other significant conditions co	ntributing to death but not resulti	ng in the ur	nderlying cause giv	en in Part I.	23e. Did	obacco use con	tribute to the	cause of death?
ds,	quires en sig ould b	ted						1 🗆	Yes 2 No		. / ~
cor	iaw rei ias be	Completed						24a. Was	psy	Were autops prior to com death?	sy findings available pletion of cause of
Re	: The cate h							1 \(\text{Yes}	2 No		No
ita	sician certifi irector	Be C	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	VO 4	Oth	ace of Death (Ch		OVT OH	(C/5.)	selli Ving
of V	g Physer this eral di	e: To	27. Manner of Deat		b. Time of	28c. Injur	y at	Home 5 Res 28d. Describe	how injury occur		
on (ending eath. rr: Afte	icat	Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	injury	M 1 🗆	Yes 2 No				
Visi	or Atter frer de birecto in by ti	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, stre	et, factory, office		28f. Location (City or To	Street and Numi wn, State)	oer or Rural F	Route Number,
Ö	ours a leral C		29a, Certifier 1 Certifying Phys	ician: To the best of my knowledge	ge, death o	ccured at the time	date and place.	and due to the ca	ause(s) and man	ner as stated	
	n 24 h	Medical	(Check 2 Medical Exami	ner: On the basis of examination are Practioner: To the best of my kr	nd/or invest	igation, in my opinie	on, death occurred	d at the time, date	and place, and d	ue to the caus	se(s) and manner stated.
	To the To the comp		29b. Signature and title of certifier)		29c. License			29d. Date sign	_	
P	1,75,447		× 7 50	W		02	f35		7-1	1-11	
1	_10		30. Name and address of person who	ompleted cause of death (Item 23	Ba) (Type, P	rint) Dr. K	rishan N	lathur	MA) <	0646
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signature	00	ے د	1 -01	U -		0	0 1 0
	Registr		JUL 1 4 2011 De	32. Registrar's Signature	-			_			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death July 201^{Year} Physician/ Ralph S. Payne 4:52 amM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sandy Spring Montgomery Brooke Grove Rehab and Nursing Ctr 8. Date of Birth (Month, Day Ye Sept 2/ 9. Birthplace (State or Foreign Country) WI If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Numbe Funeral Months Days Hours 1**X**□ M 2 □ F 80 288-26-8861 Director Usual Residence of Decedent 10d. Inside City Limits ms 23a or 28a-f show must be notified at 10b. County 10c. City, Town or Location 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 Ves 2 No Rockville MD Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 20853 14533 Woodcrest Drive 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 Specify: White If Yes, Give 1955-58 Year or Dates. 1 Yes 2 No Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Systems Accountant Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary McLeod 0 Ralph Payne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6574 River Run, Columbia, MD 21044 Cathy L. Stach/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 X Cremation 3 ☐ Removal from State 5 Department of Important: If any injury or Metropolitan Crematory Jul 13,201|1 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Collins Funeral Home 21. Signature of Funeral Service 500 University Blvd West, Silver Spring, MD 2090 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 2 neu Monio Week disease or condition resulting in death) Medical ue to (or as a consequence of) Examiner 18055 011/2 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami the attending physician and hed for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Day in the past 12 months? Month Pregnant at time of death detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death?

1 Yes 2 No autopsy page 2 certificate has performe 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, examiner' Hospital Other 2 No ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of injury (Month, Day, 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Excertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 the only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

51

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 11:45Рм Frederick T. Pierce July 201 Medical 4a, Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Charlotte Hall St.Mary's Charlotte Hall Veterans Home 6. Sex 1 ☐ M 2 ☐ F If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months Hours (Month Day Year) **Virginia** 87 220-14-0111 Director 2/03/1924 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County with the Maryland Director 1 Yes 2 XNo Howard Ellicott City 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21043 USA 8720 Ridge Rd. Apt. 210 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) hours after death 12. Was Decedent Ever in U.S.
Argued Forces?
1 Pyes 2 No
If Yes, Give 194 Race - American Indian, Black, White, etc. 11. Marital Status 1943 δ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify.White 1945 3 Widowed 4 Divorced Completed Year or Dates and Mental Hygiene.
is marked other than "naturaumatic event, the Medical. 15 Decedent's Education 16a Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) A&P Coffee Plant Plant Worker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bessie Lee Blanchard Richard L. Pierce permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11100 Chambers Ct. Woodstock, Md. 21163 Charlene Fuhrman/niece Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ♣ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/13/2011 | Marriottsville, Md. 4 Donation 5 Other (Specify) Crest Lawn Memorial 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc. Signature of Funeral Service MOO845 4112 Old Columbia Pike Ellicott City, Md. 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final RENAL CARCINOMA Physician/ CELL disease or condition) Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Examine requires that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician and the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live Birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? signed by the a Yes 2 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYPERTENSION ESSENTIAL 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ thknown Division of Vital Records, After this certificate has been significate has been significated and altered of the second of the s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an • Hospital or Attending Physician: The law 124 hours after death. • Funeral Director: After this certificate has b performed' 2 No 1 Yes 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) completed filled in by the funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ပ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0067788 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Prince Frederick MD- 20634 JA KODALI 100 Hospita egistrar's Signatu State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	.=.		For State Registrar		-	epartment of F Certificate of			ene g. No 2011	24005		
	Physici /Medi		DAVID	st) SCOT	F	LUES		2. Date of Death Month JULY	Day 2011 Year	3. Time of Death 6:15 A M		
	Examir		4a. Facility Name (If not institution, given 6779 Wood Duc			4b. City, Town, o	r Location of Death		4c. County of Dea			
	Funeral Director		5. Social Security Number 6. 5		(In yrs. last birth			8. Date of Birth (Month, Day, Sept. 6,	9 Bir	thplace (State or Foreign ountry) nsylvania		
	р		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location			10d. Inside City Lim			
	Ba-f sh	Director	Maryland Freder	ick	Fre	derick				1 □Yes 2 No		
	ath with the 23a or 2		10e. Street and Number 6779 Wood Duc	k Court		10f. Zip Code 21703		1	Og. Citizen of What Co United St	•		
21215-0036	72 hours after death with the Maryland "natural", or Items 23a or 28a-f show odgel Examiner must be notified at	d by Funeral	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 □ Yes 2 ☒ N If Yes, Give Year or Dates:		13. Was Decedent of h If Yes, specify Cub 1 ☐ Yes 2 ☑ No		pecify Yes or No- pecify Yes or No- pecify Yes or No-	14. Race - Ame Black, Whit	e, etc.		
215-	d 2 should be filed within 72 hou th and Mental Hygiene. 7 is marked other than "natural traumatic event, The Medical E.	Completed	15. Decedent's En (Specify only highest grade) Elementary/Secondary (0-12)	ade completed)		Decedent's Usual Occup Give kind of work done life. DO NOT use retire	oation during most of work d)	king 1	6b. Kind of Business	/Industry		
d 21	filled wit Hygien other th	e Con	17. Father's Name (First, Middle, Last	College (1-4or 5+	Pr	oduction M		ne (First, Middle, M	Horticult	ure		
Maryland	ould be Mental narked c	To B	Joseph R.	Plues			Loretta		Bohince			
, Mar	ges 1 and 2 should it of Health and Mer If item 27 is marke or other traumatic		19a. Informant's Name/Relationship (Patrick Plues	Type.Print) / Brother	i	Mailing Address <i>(Street</i> 242 Carpent	_			Zip Code) 19146		
nore	Pages 1 and 2 nent of Health a nt: If item 27 is iny or other tra		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐		1	Disposition (Name of crematory or other place			20c. Location - City or			
Baltimore,	permit. Page Department of Important: If any Injury or once.		4 □ Donation 5 □ Other (Specification 21. Signature of Funeral Service Licer	-	union (Cemetery 22. Name and Addre	ess of Facility St	./2011 auffer Fi	uneral Hom	nnsylvania es, P.A.		
	40 % & Q		23a. Part 1. Experthe disease, or com	plications that caused to	the death. Do no				derick, MD	21/02 Approximate Interval Between		
	Physician // /Medical	Physician Immediate & use (Final disease or condition resulting in death) a. Atherosclerofic (ardiovas cular) seuse Year										
	Examiner		Sequentially list conditions,	b	consequence of							
	ecuted ind transit	Examiner	ii any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c	consequence of							
68760,	rificate be executed up physician and as the burial-transit	ledical Ex	resulting in death) Last	Due to (or as a	consequence of):						
			IF FEMALE:	23c. If yes, outcome of	of pregnancy							
P.O. Box	that the death cert ed by the attending detached for use a	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 4 ☐ Pregnant at 9 ☐ Unknown	Fetal death	3 ☐ Ectopic pregnance 5 ☐ Other (specify) _	ey		23d. Date of de Month	livery Day Year		
	w requires that the d sbeen signed by the should be detached		Part II. Other significant conditions of	contributing to death but	t not resulting in t	he underlying cause giv	en in Part I.	23e. Did tob	acco use contribute to s 2 ☐ No 3 ☐ P	o the cause of death?		
Vital Records,	law requals been 2 should	Completed by	Hypertens,	on.				24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of		
tal B	slcian: The law s certificate has b irector, page 2 sl		25. Was case referred to medical				26 Place of Deet	perform 1 □ Yes 2 th (Check only one	ed? death? No 1 □ Yes	-		
of Vi	> .07 0	To Be	examiner? 1 Ar Yes 2 □ No	Hospital: 1 ☐ Inpatier	it 2 ☐ ER/Outp	atient 3 DOA Oth	or:		nce 6 □ Other <i>(Spe</i>	ecify)		
ion o	Attending Predeath. sctor: After in the funera	atjon:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day,		ury Wor	ry at k? Yes 2 □ No	28d. Describe how	w injury occurred			
Division		Certification: To	3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.	y - At home, farm (Specify)	n, street, factory, office		28f. Location (Str. City or Town,	eet and Number or R State)	ural Route Number,		
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical (29a, Certifier 1 Certifying Ph (Check only one) 1 Medical Exar	nysician: To the best of niner: On the basis of and manner stat	examination and/	death occurred at the ti or investigation, in my o	me, date and place opinion, death occur	, and due to the ca rred at the time, da	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)		
	To t with To t	Σ	29b. Signature and title of certifie	son MIN	DMF	29c. Licens	37197	29	od. Date signed (Mont			
	8		30. Name and address of person who	completed cause of de	ath (Item 23a) (Ty	/pe, Print)	Street	- En-	1. 1. 1.	12011 12011		
	Sta Registr		31. Date filed (Month, Day, Year)	011 32. Pegistrai	's Signature	Lake!	sir cel,	IV CA	enck, 1	W CIM		
					F 1	/						

State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 2:30 PM mslie Medical 201 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 120 PARKS POINT **QUEENSTOWN OUEEN ANNE'S** Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 **X** M 2 □ F Days 81 03/14/1930 213-26-5487 MARYLAND Director Usual Residence of Decedent 10a, State 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Directo or 28a-f QUEEN ANNE'S QUEENSTOWN 1 Yes 2 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 120 PARKS POINT 21658 UNITED STATES within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. ò 1 Never Married 2 Married þ 1 Yes 2 No Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: "natural", Specify: WHITE Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) LAWYER 12 5+ LAW Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ည ZADOC TOWNSEND PARKS, JR. HARRIET FORESTER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a 7238 MORGAN ROAD, WOODBINE, MD DONNA WILNER / DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of Department of Important: If it any injury or or CHESAPEAKE CREMATION 07/12/2011 1 🗆 Burial 2 🗶 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) STEVENSVILLE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD. CHESTER, MD 21619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ renal talure disease or condition weeks Medical resulting in death) Due to (or as a consequence of) Examiner weeks Lro sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Years burial-transit Due to (or as a consequence of): cancer and attending physician Physician/Medical that the death certificate be Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Pregnant at time of death detached the 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? þ eq pinous neart disease To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 🗙 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 200 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident 3 Suicide 4 Homicide Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D47311 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ster, Mid 21619 - Suzanne Niemela Mid 630 101 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 24007 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2011 Physician/ July 11 Bessie Krupsaw Porton 2135 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Virginia **Funeral** 8. Date of Birth 1 - M 2 X F Months Days Hours Min. Month, Day, Year) 10 Director 225-07-4313 100 Usual Residence of Decedent ms 23a or 28a-f shov must be notified at death with the Maryland 10b. County 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits Maryland Montgomeru Rockville 1 Yes 2 X No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a 300 Lisa Oaks Way 20850 U.S.A. 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Completed by 1 Never Married 2 Married Maryland 21215-0036 If Yes Give 1 Yes 2 X No Specify: 3 X Widowed 4 Divorced Year or Dates Caucasian 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Contee Cement of Health and Mental Hygie fitem 27 is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ္ဝ Rubin Rosenberg Blume Hertzberg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once. Judith Solomon - Daughter 300 Lisa Oaks Way. Rockville. Maryland 20850 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State 1 🛛 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King David Mem. Grdns: 07/14/2011 Falls Church, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home,]|11800 New Hampshire Ave., Silver Spring,MD 20904 awstu 23a. Part 1. Enter the disease, or complications that it used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on a chaline. Approximate Interval Between Immediate Cause (Final myocardial Onset and Death Physician/ acute disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner comestive heart failure Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury sician and burian reason that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Pregnant at time of death Day Year 5 Other (specify) ed by the a detached f s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 s Hospital or Attending Physician: The L 24 hours after death. Funeral Director: After this certificate h 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 XNo မ 1 Kinpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check To the I within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and title of certification 29c. License number D071404 07-11-2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EARL H. RUDOLOH D.O. 9901 MEDICAL CENTER DRIVE, ROCKVILLE 31. Date filed (Month, Day, Year) State 32. Registrar's Sig

DHMH 17 Rev 7/2009

Registrar

JUL 13 2011

3

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland bepartment of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 0540 AM Hon a Padison 07 0 8 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner montgomery Home of Greater Washing HIBRITH IN ROCK VITIC If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 X M 2 😾 85 Yrs. Director 217-57-6011 08/01/1925 Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f sho Director Md. Rockville Montgomery 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? should be filed within 72 hours after death with 1 and Mental Hygiene. is marked other than "natural", or items 23a Funeral US 20852 11430 ive apt Was Decedent Ev Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 🙀 No If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify. White Specify. 3 Widowed 4 Divorced Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental H
Important: If item 27 is marked ott
any injury or other trensone. Peretz Padison Rachel Kronik 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11430 Strand Dr. Apt.315 Rockville md Gozhansky/daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Strial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Judean Cemetery 7/10/11 Olnev. Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility EDward Sagel Funeral Direction Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approxima e0 852 Immediate Cause (Final Dementia Physician/ Advanced disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Due to (or as a consequence of): by the attending physician a stached for use as the burial-Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bur completed filled in by the funeral director, page 2 should be detached for use as the bur page 2. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ to Thrive 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Vertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 07/08/2011 Timen Mpon 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar TIMIN

1801 E

E. Jefferson St. ROCKVILL,

20852

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death 11 Pay **Physician** July 20 ľ T 3:30 p M Glenn Herbert Rottmann /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner P.G. Crescent Cities Adult Medical Day Ctr. Riverdale If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthdav) 9. Birthplace (State or Foreign 6. Sex 8. Date of Birth (Month, Day, **Funeral** Days Hours Min 1 € M 2 □ F 215-44-8555 June 9. 1927 IL Director Usual Residence of Decedent 10d. Inside City Limits 10h County 10c. City. Town or Location 10a. State r 28a-f sh 1 ☐ Yes 2 ☐ No Director P.G. MD Adelphi 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? s 23a or 3 2504 Buck Lodge Terrace 20783 USA Funeral Pages 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23 ury or other traumatic event, the Medical Evaluing to other traumatic event, the Medical Evaluing to the 12. Was Decedent Ever in U.S.
Armed Forces?
1 ⊊Yes 2□No WWII &
If Yes, Give
Year or Dates: Korea Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married altimore, Maryland 21215-0036 1 □Yes 2 No SpecifiWhite Completed by Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Production Manager Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Herbert Joseph Rottmann Margaret Sommers ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glenn L. Rottmann/Son 9404 Union Place, Montgomery Village, MD 20886 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1 Department of h Important: If ite any Injury or ot July 12 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2011 Alexandria, VA Amers Agress Corrigns Funeral Home Inc. O University Blvd. W., Silver Spring, MD 20901 21. Signatura of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** mo 121 disease or condition resulting in death) 10 COLCAI /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any least of to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consisuence of The law requires that the death certificate be executed as the burial-tra Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) signed by the a d be detached for ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown has been signed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Dyes 2 Mo After this certificate Remote Colon 1 ☐Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1. Natural To the Hospital or Attendin within 24 hours after death.
To the Funeral Director: Aft completely filled in by the fun 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Lecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title 29c. License number D01852 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) sears bury Rel Hzatkuilk MD 20181 VORE MIS 4203/ 31. Date filed (Month State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1 - State Amended # 10e perFH FCHD KS 7/12/11 Certificate of Death

Reg. No. 24010 2. Date of Death 3. Time of Death July 7, $20^{\circ}11$ 12:21 PM Riggan 4b. City. Town, or Location of Death 4c. County of Death

10d. Inside City Limits

Approximate Interval Between Onset and Death

Day

29d. Date signed (Month, Day, Year)

July 8, 2011

Year

White

XX Yes 2 ☐ No

1. Decedent's Name (First, Middle, Last) Physician/ Irline Medical 4a. Facility Name (if not institution, give street and number) **Examiner** Frederick Frederick Northampton Manor 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, 8. Date of Birth **Funeral** 1 □ M 2 🏝 F Days Hours Min Apr. Month 200 Months Virginia 229-20-6317 86 1925 **Director** Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a, State 10c. City. Town or Location Director MD Frederick Frederick 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Oe. Street and Number 200 EAST 16TH STREET

Northampton Manor Health Gare (Funeral 21701 USA Center Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Civil Service Telephone Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Lloyd Jenkins Katie Woodcock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1473 Waggamon Circle, McLean, VA 22101 Eugene M. Lawson, Jr./Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Graham Memorial Park 1 XBurial 2 Cremation 3 Removal from State 7/11/2011 Burlington, NC 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stauffer Funeral Home 1742 opossumtown Pike, Frederick, MD 21702 Signature of Funeral Service Lice 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shower heart failure. List only one cause on each line. Immediate Cause (Final disease or condition (6 sillation Urial Ph_sician/) Medical resulting in death) Examiner disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Exami attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) signed by the at d be detached fo Unknown Hospital or Attending Physician: The law requires that the technoris after death.
 Funeral Director: After this certificate has been signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed Yes 2 Dementra 1 Yes 2 No 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one Be examiner? 2 1 No Hospital: Other: 1 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Mann of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural iniury 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

To the l 29b. Signature and title of certifier 29c. License number 01188 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 Syed Haque 700 Montclaire Ave. Frederick, MD 21701

32. Registrar's Signature

un

State Registrar

only one

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician/ Lloyd Benjamin Rose, Jr. 3:00 A^M 2011 Ju1v Medical 4b. City, Town, or Location of Death Annapolis 4a. Facility Name (if not institution, give street and number) 4c. County of Death Anne Arundel Examiner Heritage Harbour Health & Rehab If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number Sex 1 X M 2 □ F 7. Age (In vrs. last birthday) **Funeral** Months Days Hours March 29,1930 Tennessee Director 410-42-0968 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f shov 10a. State 10b. County 10c, City, Town or Location Director Maryland Anne Arundel Edgewater 1 Tes 2x No 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral USA 21037 1724 Potomac Road 12. Was Decedent Ever in U.S. Armed Forces?

1. X Yes 2 No 30If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 -30-50 1 ☐ Yes ZXXNo Specify: White 3 X Widowed 4 Divorced Year or Dates. 2-2-52 permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical E once. 15. Decedent's Education 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Draftsman Estimator Architecture Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mabel Jones Lloyd Benjamin Rose, Sr. 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9419 Old Harford Road, Baltimore, Md. 21234 Tnomas Rose/Son 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
. Veterans Cem. 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) July 14,2011 Crownsville, Md. Emeral 5 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signaturo 2973 Solomons Island Road, Edgewater, Md. 21037 23a. Pat 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Hospital or Attending Physician; The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last the attending physician a hed for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Pregnant at time of death 1 Yes 2 L 9 Unknown this certificate has been signed by the adirector, page 2 should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably Anknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other 2 No Certificate: To 1 🔲 Yes 1 Inpatient 2 I ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 28a. Date of injury (Month, Day, Year) Manner of Death 28c. Injury at 28d. Describe how injury occurred s after death. injury work? Natural 5 Pending Accident Investigation filled in by the Suicide 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a

To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year,

Registrar
DHMH 17 Rev 7/2009

State

Name and address of person

31. Date filed (Month, Day, Year)

who completed cause of death (Item 23a) (Type, Print

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 7 2:45 My Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Annapolis 7024 Channel Village Court, T-1Social Security Number If Under 1 Year I If Under 24 Hrs. **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 D F Days 78 0*2\\2*474933 Penns∀lvania 186-26-5331 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notifled at 10c. City, Town or Location 10d. Inside City Limits Director Annapolis Maryland Anne Arundel 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7024 Channel Village Court, T-1 21403 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Completed White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Aerospace Physicist N.A.S.A. ... rage 1 and 2 should be file.
Department of Health and Mental Hy
Important: If item 27 is markry injury or otherce. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Marie Crist Carl Agustus Reber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7024 Channel Village Court, T-1, Annapolis, MD 21403 Carol Bauer Reber-Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Kalas Crematory 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State permit. Page Department o Important: If any injury or 07/09/2011 Edgewater, Maryland 4 Donation 5 Other (Specify) Signatura of 22. Name and Address of Facility George F. Kalas Funeral Home e Licensee 2973 Solomons Island Road, Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events Due to (or as a consequence of) Exami and Due to (or as a consequence of) resulting in death) Last burial attending physiclan for use as the buria Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Pregnant at time of death Yes 2 No signed by the a 9 🗌 Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, cate has been signated by page 2 should b 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 1 Yes 2 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, I Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 **11** 2 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 28d. Describe how injury occurred Natural 5 Pending injury 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Description in the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Date signed (Month, Day, Year) 29b. Signature and title of certifie License number 8 0 T cause of death (Item 23a) (Type, Print)

Registrar

State

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31. Date filed (Month, Day, Year)

JUL 12 2011

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HUY ANNAPAIS MD. 21401

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Karen Redmond L. July 06, 2011 3:05 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Care Towson Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days 216-54-7006 1 🗆 M 2 🗶 F Hours Feb. 01, Year) 948 New York 63 **Director** Usual Residence of Decedent or 28a-f show notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. and the firem 27.5 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Baltimore 1 Yes 2 No 10e. Street and Number r items 23a or ner must be n 10f. Zip Code 10g. Citizen of What Country? Funeral 21234 USA 8710 Emge Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify If Yes, Give Year or Dates Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Accountant Accounting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Robert Russell Doris Buser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 210 Mid Pines Court Owings Mills, MD 21117 James Redmond / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory, INC. permit. Page 1 a
Department of H
Important; If ite
any injury or ot Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State July 08, 2011 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Eacility Barranco & Sons, P.A. 495 Ritchie Hwy, Severna Park Funeral Home Severna Park, MD 21146 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Immediate Cause (Final Onset and Death 7515 Physician, disease or condition resulting in death) Medical **Examiner** mon Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Physician/Medical Examine Die to (or as a consequence of) sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Pregnant at time of death this certificate has been signed by the ral director, page 2 should be detached g Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by discorte Diabene 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 27 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Tyes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Australia within 24 hours after death.

To the Funeral Director: After th Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Matural (Month, Day, Year) 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signat nd title of certifie 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N. Charles ST Tomson My CHMURS MO 31. Date filed (Month, Day, Year) State 112011 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death July **Physician** 2011 DOROTHY MAE RICE 9:45 P M /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death Examiner Alice Byrd Tawes Nursing Home Crisfield Somerset 8. Date of Birth (Month, Day, Year) 03/29/1911 7. Age (In yrs. last birthday) If Under 1 Year __if Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 □ M 2 X F 100 Director 215-05-7100 Maryland Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location "natural", or ftems 23a or 28a-f show edical Examiner must be notifled at 1 XYes 2 No Director Crisfield Maryland Somerset 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral death 21 E. Chesapeake Avenue 21817 USA 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or iten any Injury or other traumatic event, the Medical Examines one. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No White þ Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 **Homemaker** Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William H. Rudiger Anna White 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wesley H. Rice (Son) 46898 Grissom St. - Potomac Falls, VA 20165 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Crematory of Delmarva 07/11/2011 Delmar, Delaware 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Ticensee 22. Name and Address of Facility BRADSHAW & SONS FUNERAL HOME 306 W. Main Street - Crisfield, MD 21817 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ASCVD /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Jease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) physician Physician/Medical the as attending I for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 1 ☐ Yes 2 No 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy perforn certificate or Attending Physician: filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 20 No P 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral directors.

> State Registrar

29b. Signature and title of certifier

Vijay

M.D. - 201 Hall Highway - Crisfield, MD 21817 12 Registrar's Signature Denve S. parle

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Karumbunathan.

29c. License number

48098

29d. Date signed (Month, Day, Year)

12011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (11) Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** View 00K If Under 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** March Day 2 Year) 1915 1 □ M 2 🛣 F Davs Hours Min Forman, WV 234-40-3778 96 Director Usual Residence of Decedent show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location Director 1 X Yes 2 □ No WW Mineral Keyser 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 26726 275 Keys Street 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married 2 X No 1 ☐ Yes If Yes, Give Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 X Widowed 4 ☐ Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Second 12 (GED) onday (0-12) College (1-4 or 5+) Retail Dept. Store Sales Clerk Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Sumame) ဂ Hattie M. Runion Isaac S. Stonebreaker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26726 Rt. 5, Box 188 Keyser, Wv Howard C. Rotruck/Son 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of Jüly 2011 cemetery, crematory or other place, Keyser, WV Potomac Memorial Gardens 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funda Service Licensee 22. Name and Address of Facility Smith Funeral Home Keyser, Wv 85 S. Main Street Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 \(\sum \) Yes 2 \(\overline{X} \) No Day been signed by the should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has bage 2 s autopsy 1 ☐ Yes 2 ☐ No this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မှ Nursing Home 5 Residence 6 Other (Specify) ieral Director: After the filled in by the funeral 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b, Time of 28d. Describe how injury occurred Certificate: Natural Accident 5 Pending Investigation Suicide
Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Phurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of ျှ 70021214 2011 who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

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Ahmed Heshmet, M.D.

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32. Reg

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Mt. Airy, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death

Middli 6, Da 2011

Year 1. Decedent's Name (First, Middle, Last) Mattie B. Swint Physician/ JIMOLHY 12:30AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death
Prince Georges Clinton Southern Maryland Hospital 5. Social Security Number 7. Age (In yrs daet birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) SC 8. Date of Birth **Funeral** Days Hours 142941922 579-24-1644 **Director** or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** Upper Marlboro MD Prince Georges 1 ¥ Yes 2 □ No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7212 Antock Place 20772 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian Black, White etc. Black Armed Force

1 ☐ Yes 2 ☐ No 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) $\stackrel{\text{Elementary/Seconday (0-12)}}{11th}$ College (1-4 or 5+) Foster Parent Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Minnie Fuller Thomas Vance 19a. Informant's Name/Relationship (Type, Print)

Tobie Swint/ Husband 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zin Sode) 20772 Antock PI. Upper Mariboro, MD 20772 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Heritage Cemetery 7/13/2011 Waldorf, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Pridgen Funeral Service 9013 Annapolis Rd. Lanham, 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ TNEUMONIA Medical resulting in death) Due to (or as a consequence of): Examiner ENCEPHALOPATHY METABOLIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examiner Due to for as a consequence on To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last physician a the burial-To Be Completed by Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 X No Month Day g 🗌 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? MELLITUS IYPE DIABETES Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Ø Unknown DISEASE CHRONIC KIDNEY 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No. Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this the funeral Medical Certificate: 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending work?
1 Yes 2 No Investigation Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined within 24 hours a Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0064986 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) outs Rd Clinti

DHMH 17 Rev 7/2009

State

Registrar

4 2011

Hospital or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760 Division of Vital Records, this within 24 hours after death

To the Funeral Director: A

completed filled in by the

28a. Date of injury (Month, Day, Year) 27. Manner of Death 28h Time of 28c. Injury at 28d. Describe how injury occurred ▲Natural 5 Pending work 1 Tes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier

ID State

Medical

(Check

only one)

31. Date filed (Month

3 🗆

and title of certifie

O Name and address of person who completed cause of death (Item 23a) (Type, Print)
Ruth Kevess-Cohen, MD 8700 Georgia Avenue, #400, Silver Spring, Md 20910 registrar's Signature 32, Barke

Registrar

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D33159

29d. Date signed (Month, Day, Year)

July 12, 2011

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	1 - State of State of Registrar	Marylan		artment (tificate (Mental Hy	giene Reg. No	2011	2	4019
	Physicia		1. Decedent's Name (First, Middle, Last) Grace Harnish	Smith	,				2. Date of Dea	Da		3.	Time of Death
	Medic Examin		4a. Facility Name (if not institution, give street and number	er)		4b. City, Tov	vn, or Locat	tion of Death	<u> July </u>	8 4c	. 2011 . County of De	ath	2300 ™
	Funeral		Union Hospital of Cecil 5. Social Security Number 6. Sex 7.	. Count Age (In yrs. Ia		If Under 1	Elkt Year If Ur	On oder 24 Hrs.	8. Date of Birt	th	Cec		(State or Foreign
	Director		214-36-7615 1□M2⊠F	100	Yrs.	Months D	ays Hou		July 2,	y, Year)	11 P	ountry)	ylvania
	and show fat	or	Usual Residence of Decedent 10a. State 10b. County	10c. City	y, Town or Loc	ation	_					10d. lr	nside City Limits
	Maryl 28a-f notifie	irec	Maryland Cecil			Char	lesto	wn				1	XXYes 2 \(\square\) No
	ith with the Maryland ms 23a or 28a-f show must be notified at	Funeral Director	10e. Street and Number 427 Baltimore Street			10f. Zip Co		21914		10g. Ci	tizen of What C	,	
	72 hours after death with the Maryland "natural", or items 23a or 28a-f sho ledical Examiner must be notified at	/ Fun	11. Marital Status 1 Never Married 2 Married	nt Ever in U.S		Vas Decedent Yes, specify	of Hispanic Cuban, Mex	Origin? (Sp	pecify Yes or No- o Rican, etc.)		14. Race - Am Black, Whi	erican In	dian,
9036	hours after "natural", o	ed by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 3 ☒ Widowed 4 ☐ Divorced Year or Date		1	☐ Yes 2 🔯	No <i>Sp</i> e	cify:				Whit	:e
15-(72 hou n "natu Aedica	Completed	15. Decedent's Education (Specify only highest grade completed)		(Give k	ent's Usual O ind of work d	one during r	most of work	king	16b. K Uni	and of Business on Hosp Cecil C	s Industr	of
212	within 72 giene. ner than t, the Me	Cor	Elementary/Seconday (0-12) College (1-4 Twelve Years	or 5+)		NOT use ret		ds			Cecil C ton. Ma		
Maryland 21215-0036	ge 1 and 2 should be filed within 72 hour nt of Health and Mental Hygiene. If item 27 is marked other than "natu or other traumatic event, the Medical	To Be	17. Father's Name (First, Middle, Last) Arthur Detz (Sehr			18. M		ne <i>(First, Middle,</i> Mary Ell		,	sh	
lary	should and Mo is mar aumati		19a. Informant's Name/Relationship (Type, Print)		19b. Mailin	g Address (St	reet and Nu	mber or Rur	ral Route Number	r, City or	Town, State, Z		
	and 2 Health tem 27		Nancy S. Bowles (daught	-	P.O.			arles	town, Ma			914	
Baltimore,	Page 1 nent of ant: If it		1 X Burial 2 ☐ Cremation 3 ☐ Removal from St 4 ☐ Donation 5 ☐ Other (Specify)	ate ce	emetery, crem	atory or other	place)	07/	Date 14/11	20c. Location - City or Town, State Perryville, Maryla			
Balt	permit. Page 1 and 2 sl Department of Health a Important: If item 27 is any injury or other tra		21. Signature of Funeral Service Livins										
			23a. Part 1. Enter the disease, or complications that cau shock, or heart failure. List only one cause on each	sed the death line.	n. Do not enter	r the mode of	dying, such	n as cardiac	or respiratory arr	est,		App Inter	roximate rval Between
đ	Pnysician/ Medical											et and Death	
	Examiner	<u>_</u>	Sequentially list conditions h ATK	IAL F	FIBRIL	LATIO	N					DA	45
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3760	ficate b g physi			MIA								4E	ARS
89 x	ath certificate be executed attending physician and for use as the burial-transit	ian/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcor 1 ☐ Live Birl	th 2 - Fetal	death 3	Ectopic preg	nancy				23d. Date of de		
Box	the dea by the a tached fo	Physician/N	1 Yes 2 No 4 Pregnar 9 Unknown 9 Unknow	nt at time of de	eath 5 🗌	Other (specif	y)				Month	Day	Year
, P.O.	es that i	δ.	Part II. Other significant conditions contributing to deat	n but not resu	ulting in the un	derlying caus	e given in P	Part I.			use contribute t		
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ξ	Physi r this c ral din	욘	1 Yes 2 No 1 No Plant 1 1 In Inp. 27. Manner of Death 28a. Date of it.	niury 2	ER/Outpatient 28b. Time of	3 LJ DOA			ome 5 Resid			cify)	
The color of the c									y occurred				
Division of Vital Records,	28d. Describe how injury occurred 1										e Number,		
	the Hospital hin 24 hours the Funeral I	Medical	29a. Certifier 1 Certifying Physician: To the best (Check 2 Medical Examiner: On the basis of only one) 3 Certifying Nurse Practioner: To the basis of the control of the basis of the basi	of examination	and/or investig	ation, in my c	pinion, death	h occurred at	t the time, date ar	nd place.	and due to the	cause(s)	and manner stated.
	To the within 2 To the comple		29b. Signature and title of certifier			29c. Lic	ense numbe	er		29d. Dat	te signed (Mont	h, Day, Y	
			20. Name and address of parson who completed source of	f dooth //top: /	233)/Time 7:		ンドココ	11		20	11 /I	, ac	311
4	/		30. Name and address of person who completed cause of DANIN GAK-EL 304-306			SET S	LITE	#3 E	LKTON	MA	KYLAN	0 a	1921
	State Registra	9	B1. Date filed (Month, Day, Year) 4 2011 32. Reg	trar's Signatu	ire .	6.41	,						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Diane Veronica Shaw 2011 2118 hrsM Jul V Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anna Arundel Medical Center Anne Arundel Annapolis Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday, 8. Date of Birth 1956 9. Birthplace (State or Foreign 1 □ M 2 **X** F 577-78-1788 54 Director November 21, South Carolina Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director District of Columbia Washington 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? iral", or items 23a Examiner must be Funeral 20003 928 - 14th Street, S. E. United States 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian Black, White, etc þ 1 X Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify Specify: Black "natural", Completed 3 Divorced 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. entary/Seconday (0-12) College (1-4 or 5+) 12th grade Delicatessen Manager Safeway Stores Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H ဂ္ should be Arthur Shaw Lona Mae Brooks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Samuel Cecil Bell III (Son) 13112 Silver Maple Court; Bowie, Maryland 20715 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State July 13,2011 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mational Harmony Memorial Park Landover, Maryland 22. Name and Address of Facility R. N. Horton Company Morticians, Signature, of Funeral Ser Inc.;600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician, Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) sician and burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autonsy **Director:** After this certificate in by the funeral director, pag 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No Other: မြ 1 Tes 4 Nursing Home 5 Residence 6 Other (Specify, 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending iniury 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a To the Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one

State Registrar 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July Isatu Sesay 7 2011 0545 A. Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Year) 1967 Social Security Number Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State on Fereign **Funeral** Hours 217-75-3849 44 **Director** January Sierra Leone, Usual Residence of Decedent f show or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Montgomery Silver Spring 10e, Street and Number 10f. Zip Code ö 10g. Citizen of What Country? rtal Hygiene. ed other than "natural", or items 23a or event, the Medical Examiner must be I Funeral 20906 2032 Georgia Woods Place; Apt. 22 Sierra Leone, West Africa 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian 12, Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc 1 X Never Married 2 Married ģ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th grade Nursing Assistant Nursing Homes and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumame) ည Amadu Mohammed Sesay Ramatu Koroma-Bangura permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fatima Mary Savage (Sister) 11401 Charlton Drive; Silver Spring, Maryland 20906 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Ju1y^D9,2011 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Laurel, Maryland Maryland National Memorial Park 21. Sonature of Funeral Service 22. Name and Address of Facility R. N. Horton Company Morticians, Endage nc.;600 Kennedy Street,N.W.;Washington,D.C.20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death WEEKS Immediate Cause (Final Physician/ Severe Clostridium Difficile Colitis disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Metastatic Multiple Myeloma Sequentially list conditions d any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence of physician and the burial-transit Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregno 5 Other (specify) Ectopic pregnancy in the past 12 months? Day Year Pregnant at time of death 2 **X** No 9 Unknown Unknown þ signed by the period of the signal of the details and the details and the signal of th Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown has been sig je 2 should t Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No page certificate 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 🗶 No Other: 1 X Inpatient 2 ER/Outpatient 3 DOA ၉ 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 24 hours after death. 1 X Natural 5 Pending work?
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State Registrar M.D.;1500 Forest Glen Road; Silver Spring, Maryland 20910

teath (Item 23a) (Type, Print)

30. Name and address of person who completed cause of

Charu Meheswary,

31. Date filed (Month, Day, Year)

1 2 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State 24022 Reg. NZ Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month-AUM 0731 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Davidsonville 3219 Homewood Road Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign the (In vrs. last birthday 8 Date of Birth **Funeral** 1 🗆 M 2 🗓 Days Hours 8/8/1948 62 Belarus 098-64-1749 Director Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10b County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director 1 ☐ Yes 2 🕅 No Davidsonville Anne Arundel Marvland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 21035 3219 Homewood Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Research 5+ Artificial Intelligence Scientist vears Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Yakov Zilberg Riva Zusmanovich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3219 Homewood Rd., Davidsonville, MD 21035 Bruce W. Stein/ Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☐ Burial 2 ីX Cremation 3 ☐ Removal from State Department of Important: If any injury or once. 7/12/11 Edgewater, Maryland Kalas Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George F. Kalas Funeral Tome Fluderal Service Licensee 21. Signatur 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence on). Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit and that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use a 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months for Month Year 5 Other (specify) Pregnant at time of death 2 1 No been signed by the send of the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autonsy page death? 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) funeral director. Hospital Other: 2 1110 2 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After work? injury 1 Natural 5 Pending s after death. Accident Investigation the 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) 24 hours a Funeral L Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Eertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

MAPLOR

gistrar's Signature

DEFEASE HONY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar 24023 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 7/5/2011 5:15p ^M Ronald J. Sheinbaum Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Olney Montgomery General Hospita] If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth Age (In yrs. last birthday) **Funeral** (Month, Day, Year 10/5/43 1 🙀 M 2 🗆 F 67 Director 214-42-4110 Washingtonde Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f 1√2 Yes 2 ☐ No Rockville Montgomery 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ms 23a or must be n Completed by Funeral 14808 Marlin Terrace 20853 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14, Race - American Indian. Black, White, etc. 0 1 Never Married 2 Married Yes 2 No 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: Specify: White 'natural" 3 Widowed 4 Divorced traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) Store Owner Grocery Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be file tment of Health and Mental I rtant: If item 27 is marked c မ Goldie Moiger Arthur Sheinbaum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other tronce. <u>Ada Sheinbaum/Wife</u> <u> 14808 Marlin Terrace Rockville, Md.</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State Judean Cemetery 7/7/11 Olney, Md. 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arresponds to Cause (First) 1170 Rockville Pike Interval Between Onset and Death Immediate Cause (Final Physician/ SEPTIC SHOCK disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner BACTEREMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) attending physician and for use as the burial-trapsit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death 9 Unknown 9 Unknown P.O. s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ASPIRATION PNEUMONIA 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? RESPIRATORY FAILURE 24a, Was an has autopsy performed? 1 Yes 2 No To the Hospital or Attending Physician: "
within 24 hours after death.

To the Funeral Director. After this certific: completed filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ne Hospital or Attending Ph n 24 hours after death. ne Funeral Director: After th 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day, Year) D59418 Meurister inco 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Oluyemisi 18101 Prince Philip Dr. Olney, Md 20832 Adewunmi 31. Date filed (Month. Day, Year, 82. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 12 per / fh 2933 11-8-12 yt State of Maryland / Department of Health and Mental Hygiene 24024 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 9:00 P M Month 07 08ay 20^{Yea} John Lewis Sechrest Jr Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Cheverly Prince Georges Prince Georges Hospital Social Security Number 6. Sex 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 ₹ M 2 □ F Manth, Day, Year 25 Aldie, VA 578-26-0742 86 **Director** Usual Residence of Decedent 28a-f shov 10b. County 10d. Inside City Limits 10a. State 10c. City. Town or Location Examiner must be notified at Director 1x Yes 2 □ No MD Prince Georges Upper Marlboro 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 14000 New Acadia Lane#205 20774 US items 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Ves 2 No. 1943

If Yes, Give 1948 Black White etc "natural", or ≥ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after Specify: Black 1 Yes 2 No Specify Completed 3 Widowed 4 Divorced 1967 Year or Dates. injury or other traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Locksmith DC Public School Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Lewis Sechrest Osie Grey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health aitem 27 i Winifred Sechrest / Wife 14000 New Acadia Lane #205, Upper Marlboro, Md 20774 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date **UNK** permit. Page 1 a
Department of I
Important: If ite
any injury or ot 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Arlington, Va Arlington National 21. Signature of Funeral Service License 22. Name and Address of Facility McGuire Funeral Services, Inc. 7400 Georgia Ave NW Washington 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Multiple myeloma Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Tan S and Due to (or as a consequence of): burialphysician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
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5 Other (specify) in the past 12 months? Month Dav Year Pregnant at time of death 1 Yes 2 No as been signed by the 2 should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed . Were autopsy findings available prior to completion of cause of 24a. Was an Jas autopsv death? perform certificate 1 Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 Yes ျပ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred Certificate: injury work?
1 \(\sum \) Yes 2 \(\sum \) No Natural 5 Pending within 24 hours after death.

To the Funeral Director: At Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 18992000 mukemii Abdellu, wo 4105/2011 12200 Annapolis Rd-Suite 229; Glendale, 41320769 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Abdella Mukemil 31. Date filed (Month, Day, Year) State JUL 13 2011 Registrar

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	Funeral Director		5. Social Security Number 0 3 6 - 1 6 - 1 1 8 3 1 Usual Residence of Decedent	ex 7. Age (In yrs. lasi 88	t birthday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	9. Bi	rthplace (State or Foreign ountry) Mass.
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	State of Maryland / Department of Health and Mental Hygiene	2011	2402

	Registrar Certificate of Death Reg. No.															
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Baltimore, MD 21215-003 permit. Pages 1 and 2 should be filed withi Department of Health and Mental Hygiene. Important: If iten 27 is marked other thingy or other fraumante event, the Med		Donation 5 Other Sp. 1. Signature of Suneral Service)	I Ch	arles 22.	Me Nan	mori ne and A	al (ddress o	cem of Facility						
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38760, rtificate be ing physici as the buri	IF 23	FEMALE: b. Was decedent pregnant in the		If yes, outc	ome of preg	_	etal	death	3	Ectopic	pregnancy	,		Date of d	elivery Da	ay Year
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Vital ysician: ysician: director.	සු ²⁵	5. Was case referred to medical examiner?	Hospital:	1 Inpa	tient 2	ER/Outpatier	nt 3		10	thes =	Check only Nursina H		Residenc	e 6	Other:	
of Vital ling Physician: After this certif		1 Yes 2 No	28a	. Date of Ir (Month, Day		28b. Time of				at Work?		d. Describe h				
Division tale or Attendi	The Natural 5 Pending 1 Yes 2 No															
Division At the area of the ar	3	deterr	not be	e. Place of oecify)	Injury - At ho	ome, farm, str	eet, f	factory, o	ffice buil	lding, etc.	28f	f. Location (S or Town, S		Number	or Rura	al Route Number, City
To th withir To th compl		2 Medical Example Signature and title of certifier	and ma	nner state	d.	nd/or investig	ation		icense r		arred at the	e time, date a				h, Day, Year)
		Pot On	on '		Pa	Och -		1	D.C.M.					7, 201		, Du y , i eai /
	30). Name and address of person v Patricia Aronica-Pollak	-			23a) Examiner	٥٥		Raltima	ore Stro	et Ralt	imore MC	2122	3		
Stat	te ³¹	. Date filed (Month, D.), Yes	2011		rar's Signatu	100	,	اري	-amille	ore one	oi, Dail		144			
Registra	ar	50L 44	- 2011	July 1		70. 19	-									

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 24027 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month July Robert 2011 Glenn P^{M} Snodderly, Sr. 4:03 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 5114 Gen. Stuart Court Sharpsburg Washington Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1**X** M 2 □ F Aug. 2, 1928 Maryland 220-26-5553 82 Director Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at "natural", or items 23a or 28a-f sho 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD 1 🏋 Yes 2 □ No Washington Sharpsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5114 Gen Stuart Court 21782 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 M Married Black, White, etc. Completed by 1X Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 🗆 Widowed 4 🗆 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Technician Water Department Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Walter C. Snodderly, Sr. Nellie G. Rummel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hilda E. Snodderly/Wife 5114 Gen. Stuart Court, Sharpsburg, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State cemetery, crematory or other place; Smithsburg Crematory 7/22/2011 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Deat shock, or heart failure. List only Immediate Cause (Final Ph sician/ 07 disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Esque, traily list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after cleath.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit attending physician and for use as the burial-transi Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Unknown 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 → Yes 2 □ No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 2 🗌 No 2 Accident
3 Suicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier -0056413 Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State 7-14-11 Registrar Amend #21.22. Per FSPGCCr 24028 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June 20^{Yea} LOIS ELIZABETH THOMPSON 19:43 Рм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 42nd Avenue, Apt.617 Hyattsville Prince George's If Under 1 Year I If Under 24 Hrs Social Security Number **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🛣 F 578-66-7605 (Month, Day, Year Director 63 Nov Washington, DC Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Marvland Prince George's Hyattsville 1 X Yes 2 ☐ No 10f. Zip Code 10g. Citizen of What Country? Funeral 5805 42nd Avenue, Apt.617 20783 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗓 No Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 K Never Married 2 Married Black, White, etc. African Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: American 3 Widowed 4 Divorced If Yes, Give Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)
Disabled Elementary/Seconday (0-12) College (1-4 or 5+) None Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည 0tto James Thompson Elaine Marguerita 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leonard L. Thompson (Son) 5805 42nd Ave., Apt. 617, Hyattsville, MD 20783 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cemetery Name and Address of acility Rd.,Lanham 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ nyolardini disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner bue to (or as a consequence of) attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Year Day Pregnant at time of death certificate has been signed by the irector, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 K No 1 Yes 2 No within 24 hours after det th.

To the Funeral Director: After this certific completed filled n by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital. 1 X Yes 2 🗌 No Other: 욘 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 K Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🖾 Natural 5 \square Pending injury work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Grafflying Nurse Fractioner: To the basis of my knowledge, death occurred at the time, date and place, and one to the cause(s) and manner at estated. 29c. License number 29d. Date signed (Month, Day, Year) Do0 36786 June 26, 2011

CR 2

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KATZ

32. Registr

Porl

31. Date filed (Month, Day, Year

M.D., 123 Roesler Rord, Glen Burnie, MD. 21066

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 24029 Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death a 20 earl Physician/ Chau Tran Montuly Μ. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Potomac Montgomery Manor Care Age (In yrs. last birthday) Social Security Number 220-31-0554 9. Birthplace (State or Foreign 8. Date of Birth 2/16/19, /24/2 **Funeral** Months Davs Hours Min Director Vietnam Usual Residence of Decedent show 10a. State Md • permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10b. County Montgomery 10d. Inside City Limits 10c. City, Town or Location Potomac Director 1 X Yes 2 □ No 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? Funeral 20854 9734 Pleasant Gate Lane USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian. Armed Forces?

1 Yes 2 No 1 Never Married 2 Married Black, White, etc. δ Asian Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates Specify Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (21-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) **Thang** 18. Mother's Name (First, Middle, Maiden Surname)

Tuat
Le Tran 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20854 9734 Pleasant Gate Lane Potomac, Md. 19a. Informant's Name/Relationship (Type, Print) Do/husband Кy 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Falls Churc h, ۷a. National Crematory 7/11/11 4 ☐ Donation 5 ☐ Other (Specify) panyapakwa woldberg 1170 rockville pike 21. Signature of Funeral Service License MOO910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death 3 years Immediate Cause (Final Physician/ Hepatitis C with Liver Cirrhosis years disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** To the Hospital or Attending Physician; The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 Physician/ Completed by

within 24 hours after deaun.

To the Funeral Director: After this

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Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	b. Due to (or as a consequ	uence of):			řež					
dical Ex	that initiated events resulting in death) Last	Due to (or as a consequent	uence of):				-				
ı 🥆 ı	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of del 1 25d. Date of del 23d. Date of de										
ted by Pł	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Recurrent Pleural 23e. Did tobacco use contribute to X 1 🗆 Yes 2 🗀 No 3 🗆 F										
Somple	effusion and ascites 24a. Was an autopsy perform 27 log Yes 2 No 1 No 2 No 2 No 2 No 2 No 2 No 2 No										
3e (25. Was case referred to medical examiner?			26. Place of Death (Che	ck only one)						
2	examiner? X 1 Yes 2 No	Hospital: 1 Inpatient 2 I	cify)								
Certificate:	27. Maner of Death 1 Natural 5 Pending 2 Accident Investigation		28b. Time of injury M	28c. Injury at work? 1 ☐ Yes 2 ☐ No	dome 5 Residence 28d. Describe how inj						
Certi	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, street, facto	ory, office	28f. Location (Street a City or Town, Sta		ıral Route Number,				

State Registrar

Medical

29a. Certifier

(Check

only one 29b. Signature and title of certif

31. Date filed (Month,

K175265

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

completed cause of death (Item 23a) (Type, Print) besinva

potomac tennis

potomac,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens 24030 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Corinne H. Vincelette July 2011 6:40 РМ Medical Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death
Mitchellville Examiner 4c. County of Death
Prince George's Collington Episcopal Life Care 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** March 3, 578-40-3593 1 □ M 2 🔀 F Months Days Hours Min 82 1929 **Director** Washington, DC Usual Residence of Decedent show 10a. State 10b. County 10c, City, Town or Location notified at 10d. Inside City Limits Director Mitchellville Maryland Prince George's 28a-f 1 Yes 2xXNo 10f. Zip Code 20721 with the rms 23a or ъ 10e. Street and Number 10g. Citizen of What Country? 10450 Lottsford Road, #4117 Funeral items death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Examiner Black, White, etc. ō 1 Yes 2XXNo
If Yes, Give
Year or Dates. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 filed within 72 hours after White 1 Yes XXNo Specify "natural" Specify. Completed 3 Widowed 4 Divorced al Hygiene. d other than "natura event, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) College Professor ulth and Mental Hygie 27 is marked other r traumatic event, th Be 7. Father's Name (First, Middle, Last)
Leo J. Vincelette 18. Mother's Name (First, Middle, Maiden Surname)
Lenore Schubert . Page 1 and 2 should be file ment of Health and Mental tant; If item 27 is marked o ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10450 Lottsford Road, #4117 Mitchellville, MD 20721 Carolyn Feinglass/friend 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o once. 1 Burial 2 Cremation 3 Removal from State Baltimore Crematory 7/13/2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign June of uner II S rvice Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Metastatic Sarcoma to Lungs Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sarcoma, Left Hip Sequentially list conditions, it any leading to in recials cause. Enter Underlying Examiner Dile to for as a consequence cry Cause (Disease or linjury burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical certificate be Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ ŏ in the past 12 month Month Day Vear Pregnant at time of death the Unknown 9 Unknown P.0. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? þ Atrial Fibrillation Division of Vital Records, 1 Yes 2 No 3 Probably 4XXInknown Completed Dementia 24b. Were autopsy findings available 24a. Was an has page 2 prior to completion of cause of death?

1 Yes 2 No performed? Yes 2XXNo certificate r Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) this After this funeral c 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natura! iniury work? 1 ☐ Yes 2 ☐ No 5 Pending death. 2 Accident
3 Suicide
4 Homicide Investigation 24 hours after deat Funeral Director n by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one

6

State Registrar

29b. Signature

Rexford Babilah, MD

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9470 Annapolis Road, #306

29d. Date signed

Lanham, Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ 201 10:15 AM Vogelman, Jr. Edward Louis Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Work G Bu Anne CO me Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea **Funeral** Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days 1 X M 2 □ Months Min 92 Mary land Director 218-01-2116 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at Director Severna Park Anne Arundel MD 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? and 2 should be filed within 72 hours after death with the Health and Mental Hygiene. USA Funeral 21146 505 White Oak Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, WW II 1 Never Married 2 Married 2 Baltimbre, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White Completed 3 XWidowed 4 Divorced Specify Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) State of Maryland Food Stamp Supervisor Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Mary Fenton Wrightson Edward L. Vogelman, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health of Important: If item 27 2808 Tráxler Court Crofton, MD 21114 Diane Bennett / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State July 15, 1 X Burial 2 Cremation 3 Removal from State MD Veterans Cemetery Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 2011 Signature of Fund Service Licensee 22. Name and Address of Facility Barranco & Sons, 495 Ritchie Hwy, Severna Park Funeral H Severna Park, MD 21146 P.A. 23a. Part 1. Energies disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. List only one cause on each line. Immediate Cause (Final Onset and Death Ph sician/ disease or condition resulting in death) Medical Die to (or as a consequence of) **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy death? this certificate 1 ☐ Yes 2 X No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes Certificate: To 1 X Inpatient 2 - ER/Outpatient 3 - DOA To the magner.

Within 24 hours after death.

To the Funeral Director: After th funeral 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 5 Pending injury 2 No Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b re and title of certific Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) Maria Gaviria

DHMH 17 Rev 7/2009

State Registrar Gen Bynnightra MD ignature 21061

Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036 Physician (Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Certificate: To Be examiner? 2 No 1 1 Impatient 2 ER/Outpatient 3 DOA 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) Director: After this 28c. Injury at work? 1 ☐ Yes 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Natural 5 Pending injury 2 🗌 No ☐ Accident ☐ Suicide ☐ Homicide Investigation 6 Could not be within 24 hours after d

To the Funeral Direct
completed filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day, Year) Supariech, RSM MD Barbaro 0065485 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BARBARA SUPANICH M.D. 1500 FOREST GLEN ROAD #727 SILVER SPRING, MARYLAND 20910 31. Date filed (Month, Day, Year, 32. Registrar State 3 2011 Registrar

11-05052 Lelia Whitfield Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ena vvintneid		1- For State	te of Maryland				nd Men	tal Hy	giene		201	I	24030
Physicia	an/	Registrar 1. Decedent's Name (First, Middle,	aet)	Ce	ertificate of	Death			2, Date of Dea	Reg. No			
Medical Exami			,						Month	Day	Year	1	3. Time of Death 0534 hrs
and a sign		4a. Fecility Name (if not institution,	give street and number)		1.	4b. City, Town,	or Location	of Death	July 7, 20		c. County of D	eath	
		Westbound Landover R				Landover				- 1	Prince Geo		\$
Funeral		Social Security Number 6.	. Sex 7. Ag	e (In yrs.	last birthday)	If Under 1 Ye		er 24Hrs.	8. Date of Bi	irth(MIV	/DD/YYYY) 9.	Birth	place (State or
Director		535-50-7081	_M 2√F 6	4	Yrs		ays Hours	Min.	1-27-	194	7	reign Cour	Mississipp my)
		Usual Residence of Decedent								177			
w any		10a. State 10b. County		10c. City	, Town or Locati	ion						- 1	0d. Inside City Limits
Maryland 28a-f show d at once,	ţō		Georges	Lan	dover								1 X Yes 2 No
e Mar	Director	10e. Street and Number				10f. Zip Code			1	10g. Cit	izen of What (Countr	y?
with the Maryland ms 23a or 28a-f sho be notified at once		3512 Hubbard Ro	oad Apt. 10	2		2078				Uni	ted Sta		
ath w	Funeral	11. Marital Status 1 Never Married 2 Marri	12. Was Decedent Armed Forces?		J.S. 13. Wa	s Decedent of I es, specify Cub	lispanic Orig an, Mexican	jin? (Spe , Puerto R	cify Yes or No Rican, etc.)	0-	14. Rece - Ar White, et		in Indian, Black,
her de			1 Yes 2	X No	1	Yes 2K N	lo specific				Specify: B1.	0 0 1-	
ntrs af	d by	15. Decedent's Education (Specify	or Dates:	pleted)	16a. Deceden	t's Usual Occup	ation (Give I	kind of wo	ork done	116b.	Kind of Busine		
72 ho	ompleted	Elementary/Secondary (0-12)	College (1-4 or 5	i+)	during me	ost of working li	fe. DO NOT	use retire	ed)				,
vithin ene.	mp	12th			Regist	ration .	Admini	stra	tion	1	Hospita	1	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	ပ	17. Father's Name (First, Middle, La				-			First, Middle,	Maider	Surneme)		
127 Id be i fental arke event	Be	Roland Waterhous 19a. Informant's Name/Relationship					Le1	ia P	ringle				<u>-</u> _
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-fahe injury or other traumatic event, the Medical Examiner must be notified at once	٩	Tracee Whitfield			1.7	Address (Str					-		
and 2 sealth tem 2		20a. Method of Disposition	1/Daughter	20b.	Place of Disposi	Hubbard	Rd. A	pt.	102 La	ndo	ver MD. Location - City	20	0785
Baltimore, comit. Pages 1 and Department of He Important: I fite I		1 X Burial 2 Cremation	3 Removal from Sta	te	crematory or oth	er place)	Sinctory,		Date	200.	Location - Oity	OI IC	own, State
Baltimore permit. Pages 1 Department of F. Important: If i		4 Donation 5 Other Spec 21. Signature of Funeral Service Lice		Ш.,	Rock Cr			7-13	3-2011	Wa	shingt	on	DC
Department in jung in		To To a series of	Haller	1	300	ame and Addre	SS OT FACILITY	John	n T. Rh	nine	s Fune	ral	Home
Physician		23a. Part I. Enter the disease, or con	mplications that caused	the deeth	n. Do not enter th	5 12th ne mode of dying	g, such as ca	ardiac or n	Wasnir espiratory arr	ngt c	on DC 2 ock, or heart	001	. / Approximate Interval
/Medical		failure. List only one cause on	each line. e. Multiple Injuries									ł	Between Onset and Death
:xaminer		or condition resulting in death)	Due to (or as a conse	quence d	of):				-			\dashv	
		Sequentially list conditions,	b										
	Examiner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a conse	quence d	of):							- 1	
=	xan	(Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	quence c	of):			_				+	
ecuted and - transit			d										
68760, certificate be executed nding physician and use as the burial - transi	Medical	UNPENDED	AMENDED										
3760, ficate by g physic s the bur		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcom	e of preg						23	d. Date of deliv	/егу	-
OX 6876 eath certificate attending phy for use as the l	Si	past 12 months?	1 Live birth 4 Pregnant at t	ime of de	ath -	al death 3	Ectopic	pregnanc	у		Month	Day	/ Year
	Physician/	1 Yes 2 No 9 V Unknow	w⊓ 9 Unknown		J Oth	er (Specify)							
P.O. Es that the digned by the		Part II. Other significant condition	s contributing to death	but not r	esulting in the ur	nderlying cause	given in Par	t I.	23e, Did to	bacco	use contribute	to the	cause of death?
— № gy n	ğ Ş								1 Yes	2	¶No 3∏F	robab	ly 4 Unknown
Division of Vital Records, tal or Attending Physician: The law require is after death. al Director: After this certificate has been side in by the funeral director, page 2 should be.	Completed								24a. Was autop				osy findings available
Reck The lar	Ē	-								med?	death	?	
of Vital Recing Physician: The After this certificate uneral director, page	Be C	25. Was case referred to medical				26.Plac	e of Death (Check on		2		165	2 No
Vit hysici	2	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatier	t 2	ER/Outpatient		Other			Reside	nce 6 🗸 Ot	her: S	cene
ding Ph		27. Manner of Death	28a. Date of Injur Jul 7, 2011	er)	28b. Time of In		ury at Work?	0	8d. Describe				
sior ttend death. ctor:	ä	1 Natural 5 Pending 2 ✓ Accident Investiga			0526 hrs	1 -	Yes 2	No S	ubject ped	estria	in Struck		
lor A after Dire din b	Certification:	3 Suicide 6 Could no			ome, farm, street	t, factory, office	building, etc	. 28	Bf. Location (S or Town, S		nd Number or	Rural	Route Number, City
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: Completely filled in by the	<u></u>	4 Homicide determine 29a. Certifier	Toposii) Toac						'B Landover	Road			d, Landover, MD
the H in 24 the F	<u>8</u>	(Check only 1 Certifying Physi	cian: To the best of my er:On the basis of exam	knowled	ge, death occurre	ed at the time, o	late and place	ce, and du	ue to the caus	e(s) an	d manner es s	tated.	Quan (a)
To t	Medical	29b. Signature end title of certifier	and manner stated.			29c. Licen		uneu at ti	ne ume, date				
	-	11/1	all MD	_			.M.E.				Date signed (vionth	, <i>uay,</i> rea <i>r)</i>
10	ŀ	30. Name/end address of person who	o completed as see	oth /lt	220)					July	7, 2011		
6			o completed cause of de Assistant Medical I			Baltimore 9	Street. Ba	ltimore	. MD 2122	23			
Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's	Signatu	ire.				,				
Registr		JUL 1 3 2011	Terres D.	100	ares								

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State of Maryland / Department of Health and Mental Hygiene

		-	For State Registrar		artment of Health and N <i>tificate of Death</i>	nental Hygier/ Reg.	2011 21.021
	Physicia		1. Decedent's Name (First, Middle, Last) GENEVA L. U	Vashington		2. Date of Death	Day Year 3. Time of Death
	Medic Examin		4a. Facility Name (if not institution, give street at 406 BIRCHLEAF AVEN	nd number)	4b. City, Town, or Location of Death CAPITOL HEIG		4c. County of Death PRINCE GEORGE'S
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea JULY 16 1	g. Birthplace (State or Foreign Country) 931 GEORGIA
	yland f show ed at		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo			10d. Inside City Limits
	h the Mar 3a or 28a- be notifi	al Director	MD PRINCE GEORG	GE'S CAPITOL	HEIGHTS 10f. Zip Code 20743		1 1 Yes 2 □ No Citizen of What Country?
336	ge 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	d by Funeral	1 Never Married 2 Married 1 If Y	ned Forces?	Vas Decedent of Hispanic Origin? (Spr Yes, specify Cuban, Mexican, Puerto ☐ Yes 2 No Specify:	ecify Yes or No-	14. Race - American Indian, Black, White, etc. Specify: BLACK
Maryland 21215-0036	72 hours an "natur Medical E	Completed	15. Decedent's Education (Specify only highest grade com	pleted) 16a. Deced	lent's Usual Occupation kind of work done during most of work O NOT use retired)	ing 16b	. Kind of Business Industry
d 212	led within Hygiene. other thar ent, the N	Be Co	Elementary/Seconday (0-12) Col 1 2 TH 17. Father's Name (First, Middle, Last)	lege (1-4 or 5+)	STIC	e (First, Middle, Maide	PRIVATE en Surname)
ylan	should be filed and Mental Hyon is marked other raumatic event.	입	LEO_SMITH		CORRIN	E BYRD	
, Mar	1 and 2 shou of Health and item 27 is m other traum		19a. Informant's Name/Relationship (Type, Prin HERMAN L. WASHINGTON)	1	ng Address (Street and Number or Run 66 WILDE LAKE TERF	ACE COLUM	r or Town, State, Zip Code) BIA, MARYLAND 21044
Baltimore,	permit. Page 1 ar Department of He Important: If iten Ant. viury or oth once.	Ц	20a. Method of Disposition 14 Burial 2 ☐ Cremation 3 ☐ Remov. 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Dispo cemetery, cren HARMONY	cemetery 7/16	5/11 L	. Location - City or Town, State ANDOVER , MARYLAND
Balt	Depart Import		21. Signaturi of meral Servin Licensee	22			NS FUNERAL HOME, INC. LLE, MARYLAND 20785
	Physician/ Medical Examiner sthe private transit	edical Examiner	Sequentially list conditions, if any, leading to manufact cause. Enter Underlying Cause (Disease or linjury that initiated events c.	on each line. A Consequence of): Due to (or as a consequence of): Due to (or as a consequence of):		T others	Approximate Interval Between Onset and Death
	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. Of the Funeral Director: After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the	₹	in the past 12 months?		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
ls, P.O.	uires that the signed by all the deta	þ	Part II. Other significant conditions contribution	ng to death but not resulting in the u	nderlying cause given in Part I.		2 No 3 Probably 4 Honknown
Division of Vital Records,	2 3S	Completed				24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 No
Vital	ysician s certifi director	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital	: 1 Inpatient 2 ER/Outpatier	26. Place of Death (Chec		6 Dother (Specify) D+RS
on of	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate he completed filled in by the funeral director, page	Certificate: 1	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	Date of injury (Month, Day, Year) 28b. Time of injury		28d. Describe how in	£4 -2 m2
Divisi	tal or Atture safter de al Directo ed in by t		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e	. Place of Injury - At home, farm, stre building, etc. (Specify)	eet, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
	he Hospil in 24 hour he Funera pleted fill	Medical	(Check 2 Medical Examiner: On	the basis of examination and/or invest	occured at the time, date and place, ar ligation, in my opinion, death occurred a death occurred at the time, date and place	t the time, date and pla	ace, and due to the cause(s) and manner stated.
	vith vith 70 to to to to		29b. Signature and title of certifier		29c. License number 0723400	29d.	Date signed (Month, Day, Year)
R	5		30, Name and address of person who complete	ed cause of death (Item 23a) (Type, F	wise Hornway	whais	mn 21401
	Stat Registra		31. Date filed (Month, Day, Year) JUL 1 3 2011	d cause of death (Item 23a) (Type, F			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryland / Registrar	Depa Cer	irtment of F tificate of L	Health a Death	and M		giene 0		24035
	Physicia Medic		1. Decedent's Name (First, Middle, Last) James Russel Weitzel		-			2. Date of Dea		Year	3. Time of Death 2:15 p M
	Examir		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or				4c. County		
س	Funeral		2816 Blazer Court 5. Social Security Number 6. Sex 7. Age (In yrs. last bit	rthdav)	Silver		_	8. Date of Birti	Montg		
	Director		193-18-2734 1 ¹ M 2 □ F 85	Yrs.	Months Days	Hours		Nov. 8		Count	place (State or Foreign
	nd Now	Ļ	Usual Residence of Decedent 10a. State 10b. County 10c. City, Tow	vn or Loc	ation					1,	Od Isaida City Limita
	larylar Sa-fsl ified	Director	MD Montgomery Silver							"	0d. Inside City Limits 1 ☐ Yes 2 🏝 No
	the N 1 or 28	ä	10e. Street and Number		10f. Zip Code				10g. Citizen of V	Vhat Coun	try?
	h with 1s 23a nust k	Funeral	10710 Margate Road		2090	1			USA		
	r deat or iten niner r		11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 ▼ Ves 2 □ No.	13. W	as Decedent of H Yes, specify Cuba	spanic Orig n, Mexican,	in? (Spe Puerto l	cify Yes or No- Rican, etc.)		e - America k, White, e	
8	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	ed by	1 Never Married 2 Married 1 X Yes 2 No If Yes, Give Year or Dates. 1943–46	1	☐ Yes 2 ☐ KNo	Specify:			Specify: White		
21215-0036	2 hou "natu edical	Completed			ent's Usual Occup ind of work done o		of workin	ag .	16b. Kind of Bu	siness Ind	lustry
121	ithin 7 ene. r than the Me	Com	Elementary/Seconday (0-12) College (1-4 or 5+)	life. DC	NOT use retired)	iamig most	or working	ig .	TT 1 + 1	0	
<u>م</u>	illed w al Hygi I other vent, I	Be	17. Father's Name (First, Middle, Last)	rna	rmacist	18. Mothe	r's Name	(First, Middle, I	Health Maiden Surname		
ylar	should be filed v h and Mental Hyg 7 is marked othe traumatic event,	70	Russel Culp Weitzel			Nel	llie	Thompso	on		
Maryland	2 shou Ith and 27 is m		I .		g Address (Street a				-	•	
	and 2 Healt tem 2				Margate ition (Name of	Road,			zing, MD 20c. Location -		
E E	Page 1 ment of ant: If it ury or c		1 X Burial 2 Cremation 3 Removal from State cemeter	ery, crema	atory or other place			ate 1 v 13 2011		•	
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature Fyreral Sawra Licen.ee						Silver	Spri	ng, MD
**			flast of the	50	0 Univer	sity I	31vd	. W., S	ilver S	ring	, MD 20901
ı			23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	not enter	\sim	Λ	1				Approximate Interval Between Onset and Death
	Ph_sician/ Medical		disease or condition resulting in death) a. Due to (or as a consequence	a 9	e Ker	al	Wi	rease			Onset and Death
	Examiner	_	Sequentially list conditions.	0.17.							
	ed sit	Examiner	if any leading to immediate cause. Enter Underlying	otj.						141	_
	be executed sician and burial-transi	Exa	Cause (Disease or iinjury that initiated events resulting in death) Last C. Due to (or as a consequence	of):							
9	cate be executed physician and the burial-transit	dical	d								
6876	certificate nding physuse as the		IF FEMALE:				7737				
Rox	death ce he attend ed for us	cian,	23b. Was decedent pregnant in the past 12 months? 1 ☐ Live Birth 2 ☐ Fetal death		Ectopic pregnanc Other (specify)	у			23d. Date Mor	e of delive	ry Day Year
ų. Ž	requires that the death certific been signed by the attending I should be detached for use as	by Physician/M	1 Yes 2 No 4 Pregnant at time of death 9 Unknown		Other (specify)						
	s that the gned by the	by P	Part II. Other significant conditions contributing to death but not resulting	in the un	derlying cause giv	en in Part I.		23e. Did tol	pacco use contri	bute to the	e cause of death?
rds,	equire een si nould b	eted						1 🗆 Y	es 2 No	3 🗌 Prob	ably 4 □ Unknown
Vital Records,	The law requires ate has been sigr page 2 should be	Completed						24a. Was a autops perfori	sy p	ere autop rior to con eath?	sy findings available npletion of cause of
ř	in: The iificate or, pag		25. Was case referred to medical		OR Die	an of Dooth	(Oh + + 1)	1 🗆 Yes		Yes 2	2 🗆 No
VIE	nysicia lis cert direct	To Be	examiner? 1	utpatient	Othe	r: 4 \ Nur			ten	ipora.	ry residence
101	ing Pł		27. Man or of Death 28a. Date of injury 28b. 7	Time of injury	28c. Injury work	at	-		w injury occurre		
SIO	ttend death ctor: A / the fi	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be		M 1 🗆 '	Yes 2 🗆 N	-				
DIVISION	al or A s after I Direct d in by		4 ☐ Homicide determined 28e. Place of Injury - At home, fa building, etc. (Specify)	rm, stree	т, тастогу, опісе		2	8f. Location (St. City or Town	reet and Number , State)	r or Rural I	Route Number,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director After this certificate has completed filled in by the funeral director, page 2 s	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, (Check 2 Medical Examiner: On the basis of examination and/c	death oc	cured at the time,	date and pl	ace, and	due to the caus	se(s) and manner	r as stated	
	the lithin 2 the long the long the long the long the long left		only one) 3 Certifying Nurse Practioner: To the best of my know	ledge, de	ath occurred at the	time, date a	and place	, and due to the	cause(s) and mar	nner as sta	ted.
	2 wit 2 o		I West When was	[a. D	290. License	73็ก	5	7 ²	9d. Date Agned	120	ay, rear)
_	ا ،	}	30. Name and address of perspn who completed cause of death (item 23a) (Type, Pri	nt)	1 (11	(-	9d. Date signed 7/12 thicu	.1	/
O			31. Date filed (Month, Day, Year) 32. Begistrar's Signature	10 5	Digi	tal	9)N	i, hin	thicu	~, NU	a.
	Stat Registra	5	31. Date filed (Month, Day, Year) JUL 13 2011 32. Degistrar's Signature	Spa	akel			,			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 24036 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) July Physician/ Elizabeth Ann Wilson 2011 12:10P M Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery General Hospital Montgomery 01ney 8. Date of Birth (Month, Day, Y Nov • 19 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Min. Year) 1<u>937</u> 1 M 2 X F Months Days Hours Washington, D.C 579-46-5690 73 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director 1 Yes 2 No Md. Montgomery Gaithersburg 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe 20882 Funeral 24905 Silver Crest Drive United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White Specify: 3 Widowed 4 Divorced Completed 16b. Kind of Business Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Board of Education Secretary 0 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Gilda DiBonaventura Rocco Ruggieri 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24905 Silver Crest Drive, Gaithersburg, Md. Gene F. Wilson / Husband 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 🗷 Burial 2 🗌 Cremation 3 🔲 Removal from State Silver Spring, Md. 7/12/11 Gate of Heaven Cem. 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility
Muriel H. Barber Funeral Home
P. O. Box 5038, Laytonsville, 21. Signature of Funeral Service Licensee 23a. Part 1. Enfer he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ PERITONITIS disease or condition resulting in death) Medical Due to (or as a consequence of Examiner COLON METASTATIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to for as a consequence of burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ ō Month Day Year Pregnant at time of death detached the g Unknown g 🗌 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? page 2 should be de þ 1 Yes 2 No 3 Probably 4 Unknown ACUTE RESPIRATORY FAILURE Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an SEPTIC SHOCK autopsy 1 Yes 2 No certificate Yes 2 No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) funeral director. Be examiner? Hospital 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ this 28a. Date of injury Time of 27. Manner of Death 28b. 28d. Describe how injury occurred 28c. Injury at Certificate: 1 Natural (Month, Day, Year) 5 Pending injury n 24 hours after death.

e Funeral Director: Aft
bleted filled in by the fur 1 Yes 2 No Investigation □ Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 hor To the Fune completed fi 29b. Signature and title of certifie 059418 Accuration mo JULY 8,2011 18109 Prince Philip Dr., Olney, Md. 20832 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20 GENERAL HOSPITAL MONTGOMERY ULUYEMIS ADEWUNNI, mp. egistrar's Signature

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Mon

Darke

		-		State of Maryland / Dep	artment of Health and National Prince of Death	Mental Hygie	ene	24037
	-		Registrar 1. Decedent's Name (First, Middle, Last)		Tillicate of Death	2. Date of Death	g. Nb 	3. Time of Death
	Physicia Medic		Alice Ma	ae White		Month 07	07 2011	8:30 PM
0	Examin		4a. Facility Name (if not institution, give str Southern Mary 1		4b. City, Town, or Location of Death Clinton		4c. County of Death Prince G	eorges
T	Funeral Director		5. Social Security Number 6. Sex	M 2x F 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y 12-25-	g. Birthp Count 1938 Vir	lace (State or Foreign ry) ginia
	nd now	١	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation		1	0d. Inside City Limits
	Marylar 28a-f sl	Director	Wash.,		ngton, D. C.			1X Yes 2 ☐ No
	vith the 23a or 3	aral Di	10e. Street and Number 5503 Nannie Hele	NE en Burroughs Avo	10f. Zip Code 20019	10	g. Citizen of What Coun USA	try?
	death v items	Funeral	Tr. Maria States	2. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, 6	
21215-0036	urs after tural", or al Exami	Completed by	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 Yes 2 X No If Yes, Give Year or Dates.	1 ☐ Yes 2 🛣 No Specify:		Specify: B	lack
215-	n 72 ho an "nat Medica	mple	15. Decedent's Educ (Specify only highest grade Elementary/Seconday (0-12)	completed) (Give	edent's Usual Occupation his kind of work done during most of wor DO NOT use retired)	king	6b. Kind of Business Inc	
212	withir giene ner th t, the		12	College (1-4 of 54)	Bus Driver		PG Public	School
Maryland	d be filed Mental Hy arked ott	To Be	17. Father's Name (First, Middle, Last) Robert L. Morr:	is		ne (First, Middle, Ma		
Man	d 2 should alth and Nath and Nath and Nath and Nath and Tarental and T		19a. Informant's Name/Relationship (Types Sherene Ellerbee	dgtr. 697 Hampton Ode	ing Address (Street and Number or Ru Winding Stream nton, Marvland	ral Route Number, C Nay 21113	City or Town, State, Zip C	Code)
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Mayland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	20b. Place of Disp cemetery, cre			Coc. Location - City or To Landover,	
Baltir	permit. P Departm Importar any Injur		21. Sign fire of uneral Service Licensee		22. Name and Address of Facility alph Williams, I 202 Princetons I			
			23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one	cations that caused the death. Do not er				Approximate Interval Between
F	h sician/		Immediate Cause (Final disease or condition		Embolus .			Onset and Death
4	Medical Examiner		resulting in death)	Due to (or as a consequence of):	WHES FROM	MUA	6/2/11	
	ed	Examiner	Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	Due to (or as a consequence of):		100	Tes mie	
	be executed sician and burial-transit	cal Exa	that initiated events c. resulting in death) Last	Due to (or as a consequence of):	Salvat to	10053	927	
	cate b physia the b		d					
Box 6876(Attending Physiclan: The law requires that the death certificate redauth. sctor: After this certificate has been signed by the attending physy the funeral director, page 2 should be detached for use as the	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ic. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 4 Pregnant at time of death 5 9 Unknown	Ectopic pregnancy Other (specify)		23d. Date of deliv Month	ery Day Year
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Division of Vital Records,	law require has been si e 2 should l	nplete				24a. Was an autops perform	y prior to co	psy findings available empletion of cause of
Re	n: The licate r, pag		25. Was case referred to medical	- .	26. Place of Death (Che	1 🗆 Yes 2		2 No
Vita	/siclar s certi: directo	To Be	overniner?	ospital:	Other:		nce 6 Other (Specifi	0
n of	nding Phy th. : After this s funeral o		27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year) 28b. Time injury	of 28c. Injury at work?	28d. Describe how	w injury occurred	which caus
ivisio	in Signature	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Str. City or Town,	reet and Number or Rura	I Route Number,
	Hospital 24 hours a Funeral I eted filled	Medical	(Check 2 Medical Examine	cian: To the best of my knowledge, deater: On the basis of examination and/or inv Practioner: To the best of my knowledge	n occured at the time, date and place, a estigation, in my opinion, death occurred	and due to the caus at the time, date and	se(s) and manner as stated place, and due to the ca	ause(s) and manner stated.
	To the within 2 To the comple	Σ	only one) 3 L Certifying Nurse 29b. Signature and title of certifier	Practioner: To the best of thy knowledge	29c. License number Doo 4158	29	9d. Date signed (Month,	
	2		30. Name and address of person who col	moleted cause of death (Item 23a) (Type			0110+1	()
r	_3		Dr. Scott Kelso	7503 Surratts	Road, Clinton,	Marylar	nd 2073	5
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Signature	•			

DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygiene For State Registrar 24038 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ $J_{\mathbf{u}}^{\mathsf{Month}}$ David Waksman 201^{Yea} 03:09 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Annapolis Examiner Anne Arundel 430 State Street 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 6. Sex Age (In yrs. last birthday) 8. Date of Birth Days 1 M 2 - F 72 0191871939 New York 077-30-7858 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Anne Arundel Annapolis Maryland 1 🗓 Yes 2 🗌 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21403 430 State Street 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: 3 Widowed 4 Divorced Specify: White Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) United States College (1-4 or 5+) Elementary/Seconday (0-12) Naval Academy Research Engineer 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Sophie Abrams Harry Waksman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) 331 Harrison Avenue, Massapequa, NY 11/58 Roberta Schnabel/Sister 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Kalas Crematory or other place) 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State Edgewater, Maryland 7/11/11 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature of June al Septe Licensee 2973 Solomons Island Road, Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onsel and Death Physician/ 341 Medical resulting in death) Due to (or as a consequence of). **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Exami The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? signed by the atte Month Year Day Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should DISEASE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗌 No 2 - N Yes the Hospital or Attending Physician: **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month,

Box 68760

P.O.

strar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? 1 Certificate of Death Reg. No. 1. Decedent's Name (First Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 2011 04. Whitmore Everett Ε. $P^{\,\mathsf{M}}$ 3:35 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Annapolis Anne Arundel Anne Arundel Medical Center Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Age (In **Funeral** 1 XM 2 □ F 80 Months Days Hours Min July 12, 1930 220-24-9000 Mary land Director Usual Residence of Decedent show 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits Anne Arundel Annapolis MD 1 Yes 2 X No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 21409 USA 1219 Summit Drive 13. Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1948-1 X Yes 2 No 1952 If Yes, Give 1952 Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 White permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exam 1 ☐ Yes 2 X No Specify: 3 Divorced Specify. Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Public Safety Firefighter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Madge Riley Whitmore Jesse L. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1219 Summit Drive Annapolis, MD 21409 Joyce Whitmore / Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Meadlowridge Memorial July 09 Park Cemetery 2011 1 X Burial 2 Cremation 3 Removal from State Elkridge, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses P.A. Severna Park Funeral Home 495 Ritchie Hwy, Severna Park, MD 21146 23a. Part 1. Let the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition 0 Medical resulting in death) Due to or as a consequence of Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying 046-Due to lor as a consequence of: Exami physician and s the burial-transit that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of deliven in the past 12 months? 3 Ectopic pregnancy Day Year 5 Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Ses 2 No 3 Probably 4 Unknown sate has been sig page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 Yes 2 No Yes 24 hours after death.
Funeral Director: After this certific eted filled in by the funeral director, B B 25. Was case referred to medica 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 ☐ No 잍 1 Propatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred the Hospital or Attending Natural injury 5 Pending 1 Yes 2 No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical 29a. Certifier Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of ce 29c, License number 29d. Date signed (Month, Day, Year) MD (8 1 30. Name and address of berson who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day,

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			For State Registrar 1. Decedent's Name (First, Middle, La	State of N			tificate			2. Date o	Reg.	201		2 4 0	
	Physicia Medic	al	Edith Wilson							July	7, 2		Year	8:26	a ^M
	Examin	er	4a. Facility Name (if not institution, giver Holy Cross Hospi)		Sil	ver :	ocation of Despring			4c. County Montg		y	
	Funeral Director		5. Social Security Number 6.		Age (In yrs. Ia 56	s <i>t birthd</i> ay) Yrs.	If Under Months	1 Year Days	If Under 24 H Hours M			1955	9. Birthp Coun Virg	olace (State or try) Lna	Foreign
	tnd show at	o.	Usual Residence of Decedent 10a, State 10b, County			, Town or Loc	ation						1	0d. Inside City	y Limits
	Maryla 28a-f s otified	irect	MD Prince G	eorge's	Clir	iton								1 X Yes	2 🗌 No
	with the 23a or 1st be r	Funeral Director	10e. Street and Number 9412 Stream Vale	v I.n			10f. Zip	735				Citizen of V		•	
036	ge 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. if item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status 1 ☐ Never Married 2 👿 Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Deceden Armed Forces 1 Yes 2 If Yes, Give Year or Dates.	S? X No	If	as Deced	lent of His ify Cuban	, Mexican, Pu	(Specify Yes or lerto Rican, etc.)	No-		k, White,	an Indian, etc. ack	
Maryland 21215-0036	within 72 hou giene. er than "natu the Medical	Completed	15. Decedent's (Specify only highest g Elementary/Seconday (0-12)		r 5+)	16a. Decede (Give ki life. DC	ind of wor NOT use	k done du retired)	iring most of v	working		o. Kind of Bu		dustry vernmen	nt
and	be filed vental Hyg ked othe c event,	To Be	17. Father's Name (First, Middle, Last,						18. Mother's I	Name (First, Mid		len Surname)		
Aaryl	should and Me		Clarence Watson 19a. Informant's Name/Relationship (** * *					nd Number or	Rural Route Nu	mber, City			Code)	
re, r	1 and 2 if Health item 27 other t	1	William Wilson/h 20a. Method of Disposition			lace of Dispos	ition (Nam	ne of		Ln. Cli		Md 2 : Location -		wn, State	
Baltimore,	permit. Page Department o Important: If any Injury or once.		1 🛣 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec	rify)		emetery, crem surrect	ion		Ju.	1y 15,20					
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20	icate be executed physician and street the burial fractions.	edical Ex	resulting in death) Last	Due to (or a	s a consequ	ence of):									
. Box 687	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. — within 24 hours after death. — To the Funeral Director: After this certificate has been signed by the attending p. — On the Funeral Director: After this certificate has been signed by the attending p. — On pleted filled in by the funeral director, page 2 should be detached for use as the completed filled in by the funeral director, page 2 should be detached for use as the complete of the control	Σ∣	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 X No 9 ☐ Unknown	23c. If yes, outcom 1 Live Birth 4 Pregnant 9 Unknown	n 2 ☐ Fetal tat time of d	Ideath 3 🔲	Ectopic p Other (sp					23d. Dat	e of deliventh		ear
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DIVISION	ial or Atters after de al Directo		3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined	28e. Place of I	njury - At hor etc. (Spec <i>ify)</i>		et, factory	, office			on (Street Town, St		er or Rural	Route Numbe	er,
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	Vithir Withir		29b. Signature and title of certifier	0		94, 04	29c.	. License	number	, 2, 640	29d.	Date signed	(Month,	Day, Year)	
	l ~		30. Name and address of person who	completed cause of	death (Item	23a) (Type, Pr	rint) C)6257	l Pr	ome land	<u> </u>	uly 7	, 201	.1	
			1500 Forest Glen 31. Date filed (Month, Day, Year)	Rd. Silve	er Spr	ing. Me	d 209	910	can br	Ome Tand					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ 11. Day S. Whittaker 201 Tear Jul V 1:49P. Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City. Town, or Location of Death 4c. County of Death 6301 Merna Lane Lanham Prince George's Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Hours 1 M 2 XF Days 012-26-5680 Min 82 July17, 1928 Connecticut Director Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince George's Lanham 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6301 Merna Lane 20706 United States 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 X Married 2 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔯 No Specify If Yes, Give Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Registered Nurse Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ernest Chamberlain White Violet Maud Stratton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peter A. Whittaker -husband 6301 Merna Lane Lanham, Maryland 20706 permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other t or other t 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Mt. Olivet Cemetery 7/15/2011 1 XBurial 2 Cremation 3 Removal from State Frederick, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License Bonarkeho Widnessorgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Years Immediate Cause (Final disease or condition resulting in death) Priysician Dementia Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) requires that the death certificate be executed a a Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death signed by the a d be detached for 9 Unknown Parl II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Parl I. Diabetes Mellitus; Non-alcoholic Fatty Liver Disease 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown been signal Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law page 2 s has autopsy performed? Yes 2 No 1 Yes 2 No certificate funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 🗌 Yes 2 X No ျှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Magner of Death 28a. Date of injury 28b. Time of Certificate; 28c. Injury at 28d. Describe how injury occurred After 5 Pending (Month, Day, Year) 1 Natural work? within 24 hours after death.

To the Funeral Director: At completed filled in by the fu 1 ☐ Yes 2 ☐ No М Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 3 29b. Signature and fitle of certifier 29c. License number 29d. Date signed (Month, Day, Year) 105 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas Finucane, M.D. 5505 Hopkins Bayview Circle Baltimore, Maryland 21224

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year

JUL 13 2011

State of Maryland / Department of Health and Mental Hygieney 24042 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 11:25 Lawrence Young Ам July 6 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Mount Rainier Prince George's 3719 37th Street 8. Date of Birth
(Month, Day, Year)

mber 27, 1936 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days 1 🖾 M 2 🗆 F Months Hours Min. 214-38-3465 74 Director Tennessee Usual Residence of Decedent show 10a. State 10b. County within 72 hours after death with the Maryland at 10c. City. Town or Location 10d. Inside City Limits Director notified Maryland Prince George's Mount Rainier 28a-f 1 X Yes 2 No 10e. Street and Numbe 10f. Zip Code 7 10g. Citizen of What Country? be Funeral 23a must ! 3719 37th Street 20712 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. ıral", or iten Examiner r 14. Race - American Indian Armed Force Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No 3altimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: "natural" If Yes. Give Completed 3 Widowed 4 X Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) d 2 should be filed within 72 alith and Mental Hygiene.
7 27 is marked other than "r traumatic event, the Medi Elementary/Seconday (0-12) Pitney Bowes College (1-4 or 5+) Plant Supervisor 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Betty Young Unav. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) e 1 and 2 s of Health a If item 27 i 3719 37th Street, Mount Rainier, MD 20712 Sherri Young Joyner / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1. Department of I Important: If it any injury or of any injury or of ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State Metropolitan Crematory 7/16/2011 Alexandria, Virginia 4 Donation 5 Other (Specify) 21. Signature of Fundral Service Ligenses 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Ph_sician/ General Debility disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 2 No 1 Urknown Unknown been signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Senile Dementia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Diabetes Mellitus 24a, Was an performed Hypertension 1 🗌 Yes 2 🗌 No Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Hospital 1 ☐ Yes 2 🕱 No Other: ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Nesidence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending work 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined 24 hours a Medical 1 🚨 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Decelepte Rougetchou, m) D63742 7/7/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jocelyne Toukep Kouatchou, M.D., 201 East University Parkway, Baltimore, MD 21218 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 7^{Month} Da 2011 Year 7 23:42 Samantha Skylar Lynne Zakrzewski Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Univ of Maryland Medical Ctr Baltimore Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign July 5, 2011 1 🗆 M 2 🗶 F Months Maryland Director Usual Residence of Decedent 28a-f show 10a. State ms 23a or 28a-f shorms must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Prince George's Maryland Lanham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 9105 3rd Street 20706 "natural", or items ? 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 X Never Married 2 Married ģ Yes Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Specify: White Year or Dates permit. Page 1 and 2 should be filed within 72 hour pepartment of Health and Mental Hyglene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) IN/A N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Robert William Zakrzewski, II Jennifer Lynne Biddle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sl ment of Health a tant: If item 27 is 9107 3rd Street Lanham, MD 20706 Robert W. Biddle/ Grandfather 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 7/10/2011 Bowie, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ a Severe Neonatal Encephalopathy disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Maternal Cardiac Arrest Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine and -transit Maternal Thrombotic Thrombocytopenia Purpur Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical 68760 ding p IE EEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant Box (23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Year 5 Other (specify) Day 1 Yes 2 2 Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? page performed' 2 🗌 No Yes 2X No 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Hospital 2 XNo Other: 1 \square Yes ဂ္ ▼□ Inpatient 2 □ ER/Outpatient 3 □ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 24 hours a Funeral L Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) P25530 7/11/2011 gune 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)

Gaìí Cameron, MD 22 S. Greene St. Baltimore, Md 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Jennifer Lynne Zakrzewski 2011 Tuly Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Baltimore Examiner 4c. County of Death Univ. of Maryland Medical Ctr. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Maryland 1 □ M 2**X**□ F Months Days Hours Min n. 24. 28 **Director** 217-19-1976 lan. Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 No Prince George's Maryland | Lanham 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? Funeral 23a 9105 3rd Street 20706 USA or items within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces 2 Black White etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. If Yes Give 3 Widowed 4 Divorced Completed White Year or Dates th and Mental Hygiene.
27 is marked other than "natur traumatic event, the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Human Resources Specialist Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ Robert William Biddle Elizabeth Ann Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i 9107 3rd Street Lanham, MD 20706 Robert W. Biddle/ Father 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1
Department of I
Important: If it
any injury or or Hollery, Transport of Sther place) Episcopal Cemetery 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 7/10/2011 Bowie, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Diffuse Hemorrhage and Kidney Failure disease or condition Medical resulting in death) Examiner Thrombotic Thrombocytopenic Purpura Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physiciar Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 as the I IF FEMALE: use yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 23d. Date of 5X Other (specify) Peri-mortem c-section ō in the past 12 months? Year Pregnant at time of death 2 No the 2011 July Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ☐ No 3 ☐ Probably 4 X Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed death? After this certificate a funeral director, page 1 ☐ Yes 2 ☐ No Yes 2 No or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Yes 2 🗆 No မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred XNatural 5 Pending injury work? death. within 24 hours after death

To the Funeral Director: A

completed filled in by the f Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital Medical 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) July 11, 2011 P25530 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Andrea Harriott, MD 22 S. Greene St., Baltimore, Md 21201 0 Andrea Harriott, JUL 12 2011 State parke Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 24045 Reg. No. Certificate of Death 1. Decedent's Name (First Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 7 yrick 1900 Medical onald win 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death More roume Year If Under 24 Hrs. 8. Date of Birth
(Month Day, Year)
May 01,1932 **Funeral** 79 9. Birthplace (State or Foreign 1 X M 2 □ F Hours 420-52-7425 Alabama Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits with the Maryland Director MD Anne Arundel Pasadena 1 Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 23a Funeral 21122 1519 Long Point Road death 12. Was Decedent Ever in U.S. Armed Forces? 1949

1 🖾 Yes 2 🗆 No 1970

If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. Medical Examiner Black, White, etc. 0 þ 1 Never Married 2 X Married and 2 should be filed within 72 hours after Health and Mental Hygiene. em 27 is marked other than "natural", or Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Specify: Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Baltimore Gas Elementary/Seconday (0-12) College (1-4 or 5+) the & Electric Nuclear Engineer other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hazel Brewton Frank Zyriek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1519 Long Point Road Pasadena, MD 21122 Department of Health ar Important: If item 27 is any injury or other traus Nancy V. Zyriek / Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 July^{Dat} 6, 2011 1 X Burial 2 Cremation 3 Removal from State Memory Garden Fairhope, AL 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home Severna Park, MD 21146 495 Ritchie Hwy 23a. Part 1. Enter the disease, or complications that caused shock, or heart railure List only one cause on each line. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) as a consequence of Examiner REPORTION APPROVED BY MEDICAL EXAMINE Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Cause (Disease or linjury that initiated events burial-transi Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical certificate be Box 68760 as the t IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?

1 Yes 2 No Month Dav Pregnant at time of death 5 Other (specify) 9 Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, Completed anheouse 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available 24a. Was an has autopsy prior to completion of cause of death?

1 Yes 2 No certificate Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🗌 No ၉ 1 X Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify, within 24 hours after death.

To the Funeral Director: After this filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 \square Pending injury work? 1 ☐ Yes 2 💢 No Witnessed mechanism Investigation 715/2011 10:00 AM 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier соmpleted (Check 29c. License number 29d. Date signed (Month, Day, Year) Critical Care who completed ause of death (Item 23a) (Type, Print) ms 2120 State

DHMH 17 Rev 7/2009

Registrar

1 1 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ZIM 11:20 AM MARVIN 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Potomac MaNOR Care 6. Sex 1 Å M 2 ☐ F Birthplace (State or Foreign Could Win) . Social Security Number 073-28-2987 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Days Hours 75 Director Yrs Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Washington 10d. Inside City Limits 10b. County Director 1 H Yes 2 □ No 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number Apt. 109 Funeral 4200 Massachusetts 20016 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc 1 Never Married 2 Married þ Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Journalist Magazine Be 18. Mother's Name (First, Middle, Maiden Surname)
Ethel Castrow 17. Father's Name (First, Middle, Last) 2 Julius Zim 19a. Informant's Name/Relationship (Type, Print)
Anne Zim/wife 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4200 Massachusetts Ave. Apt. 109 Washington, DC 20016 20c. Location - City or Town, State Falls Church, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of National Crematory 7/9/11 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens ²²Danzansky Goldberg 1170 Rockville Pike MOO910 Rockville Md 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ENDOCARDITIS Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner SEPTIC HIP Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending nhwalness completed filled in by the funeral director, page 2 should head. MALNYTRITION Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months? Month Dav 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 Yes 2 No 25 Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 🖬 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ 28c. Injury at Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗌 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00057458 30. Name and poting software of policy placed cause of death (Item 23a) (Type, Print) Bethesda md 20814 8218 suite 305 <u>Wisconsin</u> Ave 31. Date filed (Month, Day, Year) 82. Registrar's Signature State JUL 13 2011 Registrar

			State of Maryland	-	artment of H			2.0	11	24047
			Registrar 1. Decedent's Name (First, Middle, Last)	Cer	uncate of L	- Lauri	2. Date of Dea		-	3. Time of Death
	Physicia		JOHN BROGATO				Month	Day	Year 2011	1040 AM
	Medic Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	Location of Death		4c. County		
_	LAdillii	-	CARROLL MOSPITAL CENTER		WESTMI			CARR	كال	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. la	st birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	Year)	9. Birthp	place (State or Foreign
	Director		214 01 3120 72	Yrs.	IVIOTICIS Days	Tiodio Willia	SEP 20,	1918	Mar	yland
	how at	'n	Usual Residence of Decedent 10a, State 10b. County 10c. City	, Town or Loc	cation				1	0d. Inside City Limits
	arylar ka-fs ified	ect	MD Baltimore		Ba1	timore				1 🗌 Yes 2 🗶 No
	or 26 e not	ρ	10e. Street and Number		10f. Zip Code			10g. Citizen of	What Cour	ntry?
	with s 23a ust b	Funeral Director	2838 Tennessee Avenue			21227			USA	
	Jeath items ier m	Fun	11. Marital Status 12. Was Decedent Ever in U.S Armed Forces?	. 13. V	Vas Decedent of His f Yes, specify Cubar	spanic Origin? (Spe	ecify Yes or No- Rican, etc.)		e - Americ	
36	after (I", or camir	by	1 Never Married 2 Married 1 Yes 2 XNo	- 1	Yes 2 X No			Specify		ite
8	within 72 hours after death with the Maryland gjener than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Completed by	3 LAN/Idowed 4 L Divorced Year or Dates. 15. Decedent's Education	16a Decer	lent's Usual Occupa	ation		16b. Kind of B		
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<u>Jar</u>	shou and is m		19a. Informant's Name/Relationship (Type, Print)		ng Address (Street a					
Baltimore, Maryland 21215-0036	and 2 should be Health and Metern 27 is mark		Angela M. Deuber, daughter 20a. Method of Disposition 20b. P		Golf Isla		ELL1 Date	cott Ci 20c. Location		
JOL	Page 1 ment of I ant: If it		1 X Burial 2 Cremation 3 Removal from State	emetery, cren	natory or other plac	e)				
를	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	6	4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee, George MacNa		dral Ceme					
Ba	permit. Departn Importa any inju	1	Seon E Mary		301 Frede					21228
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	and trans	Examiner	Cause (Disease or linjury that initiated events c. Due to (or as a consequent resulting in death) Last Due to (or as a consequent consequence).	ence of:						
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<u></u>	Phys r this eral di	9: To	27. Manner of Death 28a. Date of injury	ER/Outpatien 28b. Time of	nt 3 LI DOA	4 ☐ Nursing Ho	ome 5 Resid			/)
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<u>></u>	tal or rs afte al Dir ed in		building, etc. (Specify)				City or Tow	n, State)		
۵	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affect death. To the Funeral Director Affect his certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	29a. Certifier (Check (Check 2 Medical Examiner: On the basis of examination	and/or invest	tigation, in my opinic	on, death occurred a	t the time, date a	nd place, and di	ue to the ca	use(s) and manner stated.
	the Ithin 2: the Ethe F	Me	only one) 3 Certifying Nurse Practioner: To the best of my	knowledge, o	death occurred at the	e time, date and place	ce, and due to the	e cause(s) and m	nanner as s	tated.
	Vil To		29b. Signature and title of certifier	10	29c. License			29d. Date signe		
	10		10 ma 194 Kulitele,	200/ (5/2- 5		17619		70115	6,20	1 1
	(30. Name and address of person who completed cause of death (Item Hoshua MF Ruse Hitch). Mo			Avonu	E War	MINET	ar h	10 21157
	Stat	e	31. Date filed (Month, Day, Year) / 32. Registrar's Signat			- 1,				
	Registra		JUL 28 2011 Denur D. 1900	K						

DHMH 17 Rev 7/2009

			For State Registrar	State of Maryl		artment of F ctificate of			giene Reg. Na 20		24048
	Physici	an	1. Decedent's Name (First, Middle,	•				2. Date of De Month	Dav	Year	3. Time of Death
The same	/Media	al	Amelia G. Bal			4h City Town o	r Location of Death	July 2	4c. County		10:01 A M
-	Examir	er	3010 N. Ridge	,			ott City			ward	
	Funeral Director		049-24-0415	7. Age (In 1 M 2 1 F 81	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Nov. 1	th ly, Year) 7,1929		nplace (State or Foreigr untry) necticut
	and		Usual Residence of Decedent 10a. State 10b. County	100	. City, Town or Lo	cation					10d. Inside City Limits
	Maryl s-f sho	tor	MD Howard	1	Ellicott	City					1 □Yes 2 No
	with the	al Direc	10e. Street and Number 3010 N. Ridge		11110000	10f. Zip Code 210)43		10g. Citizen of	What Cou	intry?
9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the fixed of the profiled and once.	d by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? d 1 ☐Yes 2 ☒No If Yes, Give Year or Dates:		Nas Decedent of H fYes, specify Cuba I □Yes 2⊠No	dispanic Origin? (Span, Mexican, Puerto	pecify Yes or No Rican, etc.)	14. Rad Bla Specif	ck, White,	ican Indian, , etc. hite
1215-(vithin 72 h ene. than "natu in vividical	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4or 5+)	(Give life. L	dent's Usual Occup kind of work done DO NOT use retired	pation during most of work d)	ing	16b. Kind of B	usiness/Ir	ndustry
Baltimore, Maryland 21215-0036	uld be filed v Mental Hygis rked other i tic event, th	To Be Co	17. Father's Name (First, Middle, La Kalman Gubics	ast)	Dec	ciccary	18. Mother's Nam			ne)	
lary	2 shou l and N is ma is ma		19a. Informant's Name/Relationshi	(Type. Print)			and Number or Rui		· -		
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Bal	permit Depar Impor any in once.		21. Signature of Europeral Service Li	censee	F1	ineral Ho	ess of Facility Ste ome of Cat odson Aver	consvil.	le. inc.	•	
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ion of	Attending Physician; r death. scter this certifica sctor. After this certifica by the funeral director, p	Certification: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investiga	28a. Date of Injury (Month, Day, Yea	28b. Time of	28c. Inju			dence 6 □Ot how injury occur		спу)
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	To t with	2	29b. Signature and title of certifier	ho completed cause 1 eath	Physia	29c. Licens		5/	29d. Date signe	/ '	/ /
	20		30. Name and address of person w	ho completed cause Teath	(Item 23) (Type,	Print) De Geli	De Rd S	Ste 27	5 Best	6Mi	021228

DHMH 17 Rev 1/2001

State Registrar

		1 - State of Ma		artment of F <i>rtificate of E</i>	lealth and Mental <i>Death</i>	Hygien Reg. N	2011	24049
Physic Med		1. Decedent's Name (First, Middle, Last) E. Virginia	Bodie		2. Date July	of Death	2011 Year	3. Time of Death 1:48 P M
Exam		4a. Facility Name (if not institution, give street and number)	<u> </u>		Location of Death		c. County of Death	
Funera	at .	Gilchrist Hospice Care [5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)	If Under 1 Year	rowson If Under 24 Hrs. 8. Date	of Birth	Balti	more place (State or Foreign
Directo		216-18-6207	92 Yrs.	Months Days	Hours Min. June	th, Day, Year	919 Cour	Maryland
land show dat	ţ	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation				10d. Inside City Limits
e Mary r 28a-f notifie	Director	MD Baltimore	Tin	nonium				1 🗆 Yes 2 🛚 No
with the 23a or	Funeral	4 Bertwell Court		10f. Zip Code 21	093	10g. (Citizen of What Cou	ntry?
nore, Maryland 21215-0036 ge 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	à	1 Never Married 2 X Married 1 Yes 2 X N	do I	Was Decedent of His f Yes, specify Cubar 1 ☐ Yes 2 🛣 No	spanic Origin? (Specify Yes on, Mexican, Puerto Rican, etc.) Specify:	r No-	14. Race - Ameri Black, White, Specify:	
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Maryland 21215-0036 2 should be filed within 72 hours after tth and Mental Hygiene. 27 is marked other than "natural", o traumatic event, the Medical Exam		Elementary/Seconday (0-12) College (1-4 or 54 N/A	Homen	ONOT use retired) naker	9		Own H	ome
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aryla ould b nd Mer mark	-	Bernard Russell Youngman 19a. Informant's Name/Relationship (Type, Print)	10h Mailir	ng Addross (Street o	Emma Blanche nd Number or Rural Route N		<u> </u>	0-1-1
nd 2 sh ealth a m 27 is		Charles A. Bodie, Jr./ Hus		ertwell Co				Code)
Baltimore, permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other any expense.		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Dispo cemetery, cren Lorraine	natory or other place	July 26,		Location - City or To	
Balt permit. Depart Import any inj		21. Signature of Fam. Stryice Livensee Michael J. Fla	gie $\overset{22}{\text{Le}}$	Name and Address mmon Fund W. Pador	of Facility eral Home of hia Road Ti			
		23a. Part 1. Enter the disease, or complications that caused t shock, or heart failure. List only one cause on each line.						Approximate Interval Between
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SOX 68 death certif e attending ed for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deliv	ery Day Year
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To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director. After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached.	Completed					Was an autopsy performed?	24b. Were auto prior to co death?	psy findings available mpletion of cause of
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on or nding Ph ath. : After th e funeral	cate	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of injury (Month, Day,	Year) 28b. Time of injury	28c. Injury work? M 1 🔲 Y	at 28d. Descr ges 2 □ No	ribe how inju	ry occurred	,
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the Ho hin 24 I the Fu	Med	(Check 2 Medical Examiner: On the basis of exaction only one) 3 Certifying Nurse Practioner: To the be	mination and/or investi	igation, in my opinion	, death occurred at the time of	late and plac	e and due to the cal	use(s) and manner stated
wit 70		29b. Signature and title of certifier		29c. License			ate signed (Month,	Day, Year)
15		35. Name and address of person who completed cause of dea	ath (Item 23a) (Type, P		40635	7/	121/11	
		Clurch Putel 6701 DC 31. Date filed (Month, Day, Year) 32. Registrar!		# suite	4105 Multi	nere	MD SIZ	al.
Sta Regist		JUL 2 8 2011 January 9.	barre					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2011 26 WILLIAM SAMUEL CANOLES 1:00 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 101 Cloverhill Rd Pasadena Anne Arundel 8. Date of Birth (Month, Day, 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1. M 2 □ F 217 54 4351 61 10 Director 19 MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, I'm Medical Everning must be notified. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Directo MD Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 101 Cloverhill Road 21122 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 XYS 2 No 1968 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐Yes 2 No ģ Specify. Specify: 3 Widowed 4 Divorced 1969 White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Toll Facilities Police Police Officer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Howard Marc Canoles ဂ္ Marie Ann Shurba 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 Is any Injury or other trau once. 254 Glen Ct. Pasadena, Dorothy Canoles - Wife MD21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Bayview Crematory 21. Signature of Euneral Service Licensee 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death INFARC Immediate Cause (Final **Physician** MYECHRDIAL resulting in death) /Medical Due to (or as a consequence of): Examiner ROMAR Sequentially, 34 colors if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed type signed by the attending physician and abe detached for use as the burial-trar Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 □Yes 2 ☑ No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 ☐ Yes 2 ☐ Mo Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 29a. Certifier 1 🖵 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

State Registrar

(Check only

29b. Signature and title of certifier

KASTEGI

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

7-26-201

RITCHE HOUY, GLENBURNIE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7575 mo

31. Date filed (Month, Day, Year) 32. Registrar's Signature JUL 28 2011

within 2

			1- For Amend Item 1 State of Mary For Registrar	87687629 Cei	720Plans H rtificate of D	ealth and M Death	lental Hyg	giene Reg. No. 2011	24051
	Physici	an	1. Decedent's Name (First, Middle, Last) ↑ ↑				Date of Dea Month	th Day Year	3. Time of Death
	/Medic		Mary Okelly		ooper		July	24 2011	22:50 M
	Examin	ier	4a. Facility Name (If not institution, give street and number) The Johns Hopkins Hospital		4b. City, Town, or 1			4c. County of Death	
Ī	Funeral Director		5. Social Security Number 6. Sex 1. Age (In y	rs. last birthday) 72 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	9. Birth (, Year) 9. Birth Cou 2-/939 Nov.	place (State or Foreign ntry) The Cafolina
puelvo	how		Usual Residence of Decedent 10a. State 10b. County 10c.	City, Town or Loc	10				10d. Inside City Limits
backack out the Mandana	28a-f s	ecto	10e. Street and Number	Balt	10f. Zip Code			10g. Citizen of What Cou	1 Yes 2 No
di di	23a or	a Di	1608 E. Lanvale		2	1213		USA	
3-UU36	Department of Health and Mential Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examination of the indiffied at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of His fYes, specify Cubar 1 □Yes 2 174No	spanic Origin? (Spe L, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	1	
0-61213	iene. than "natur	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give life. L	dent's Usual Occupa kind of work done do DO NOT use retired) ed: ca (uring most of worki	ng	16b. Kind of Business/Ir	•
Id he filed within	Mental Hygirked other	To Be Co	17. Father's Name (First, Middle, Last) Davis Lups Comb			18. Mother's Name	(First, Middle, Boll	Maiden Surname)	
, Maryle	alth and I		19a. Informant's Name/Relationship (Type. Print) Daughte	19b. Mailin	ng Address (Street a	nd Number or Rura	St. E	or, City or Town, State, Zi	code) 2/2/3
Page 1	nent of He ant: If item ury or othe		20a. Met/fod of Disposition 1 ☑ Burial / 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Θρεσίγ)		sition (Name of natory or other place) :/	29/e1	20c. Location - City or T	own, State
Dall	Departi Importi any inju		21. Signature of Funeral Service Licensee		Name and Address	NITE	Moe 3 1.	netropolita	w Chapel
П			23a. Part 1. Enter the diservie, or complications that caused the de hock, or mart failure. List only one cause on each line.			-	-		Approximate Interval Between Onset and Death
1	nysician Medical xaminer		Imm diate Cause (Final disease or condition resulting in death) a. OVANTIAN Due to (or as a cons	cance of):	c				
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Uniderthing Cause, (Disease or injury	equence of):					
o/ou,	physician and s the burial-transit	dical Examiner	that initiated events resulting in death) Last C Due to (or as a const	equence of):					
	g phy as the	edic	0						
to the Hospital or Attending Physician: The law requires that the death certification of the contract of the c	is been signed by the attending should be detached for use as	/sician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown 23c. If yes, outcome of pregnant in the past 12 months? 4 □ Pregnant at time of 9 □ Unknown	etal death 3 🗆	Ectopic pregnancy Other (specify)			23d. Date of deliver Month	very Day Year
requires that the	signed by d be detac	d by Phy	Part II. Other significant conditions contributing to death but not r	esulting in the un	nderlying cause give	n in Part I.	23e. Did to	obacco use contribute to	the cause of death?
he law req	e has beer ge 2 shou	Completed					24a. Was a autop perfor	sy prior to c	opsy findings available ompletion of cause of
בן ד <u>י</u>	tificat or, pa	ပို	25. Was case referred to medical			26. Place of Death	1 Tes		2 L±100
Vsicia	s cer direct	0 8	examiner? 1 Yes 2 No Hospital: 1 Impatient 2	☐ FR/Outpatien	Otho	,,		lence 6 Other (Spec	ify)
oding Ph	ith. : After thi s funeral o	\vdash	27. Manner of Death 1	28b. Time of	28c. Injury Work			ow injury occurred	
al or Atter	within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - Al building, etc. (Spe	home, farm, streecify)	eet, factory, office		28f. Location (S City or Tow	Street and Number or Rui rn, State)	ral Route Number,
e Hospita	e Funera letely fille	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my Page 2 Medical Examiner: On the basis of examiner and manner stated.	nowledge, death	n occurred at the tim vestigation, in my op	e, date and place, inion, death occur	and due to the red at the time, or	cause(s) and manner as date and place, and due	stated. to the cause(s)
Toth	withii To th comp	Me	29b. Signature and title of certifier		29c. License	number		29d. Date signed (Month	, Day, Year)
			1 mm		RES	000		July 25,	2011
	>		30. Name and address of person who completed cause of death (I	tem 23a) (Type, I	Print)				
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Sig JUL 2 8 2011 A Factorial	nature			-		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Irene Natalina Dunning \mathbf{P}^{M} Tuly 2011 5:45 Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death Catonsville Charlestown Care Center 9. Birthplace (State or Foreign Country)
New York 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Months Days Hours 1 🗆 M 2 🗶 F 93 Director 119-07-3645 Usual Residence of Decedent or 28a-f show 10b County 10c. City, Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at Director Catonsville Baltimore Maryland 1 Tes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a United States 21228 715 Maiden Choice Lane or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 Yes 2 No Black, White, etc Completed by 1 Never Married 2 Married Maryland 21215-0036 WHITE 1 ☐ Yes 2X No Specify: If Yes Give 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Telephone Clerk 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Anna Savino 2 should be Nunzio Fariello other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
115 Melvin Avenue, Catonsville, MD 21228 19a. Informant's Name/Relationship (Type, Print) . Page 1 and 2 st ment of Health a 27 Richard Dunning - SON Baltimore, If item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) injury or permit. Page Department of Important: If any injury or once, Baltimore Maryland 07-27-2011 Metro Crematory INC Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation Society Of Maryland 299 Frederick Road, Baltimore MD 21228 INC 23a. Part 1. Enter the disease, or complications that, aus. the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each li Immediate Cause (Final ementia Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** hrenic 1 Cidua Sequentially list conditions, Physician/Medical Examiner Due to for each personners of: if any leading to immedicause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day g Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 1 Tyes 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an autopsy performe prior to completion of cause of death? this certificate 2 🗌 No 1 🗌 Yes Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 No 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accider injury 5 Pending M 1 ☐ Yes 2 ☐ No. Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

within 24 hours a

State Registrar

Medical

29a. Certifier

29b. Signature and title of certifier

2011

Marden 32. Registrar's Signature anka

person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2/225

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 5.16 PM Mary Sandra Vilcsek Haas 3014 Medical 2011 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore washington medical Cente Grunde 6/21 nie ANNE 8. Date of Birth (Month, Day, Year) 2/3/1948 Birthplace (State or Foreign Country) **Funeral** 1 M 2 XX Months Hours 066-38-4953 63 Yrs Director MD Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2XXNo MD Anne Arundel Pasadena 5 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? 23a Funeral 1154 Valley Drive 21122 USA or items 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 XXVever Married 2 Married 1 ☐ Yes If Yes, Give 2XXNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2XX No Specify White "natural", Specify: Completed 3 Widowed 4 Divorced Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Real Estate Agent Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Roland Vilcsek Mildred Collins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Haas Apt 4F Brooklyn, NY 11238 Mr. Richard Haas / Brother 230 Park Place 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2XXCremation 3 Removal from State 7/28/2011 Glen Burnie, MD 21061 Atlantic Crematory 4 Donation 5 Other (Specify) 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of The Service Services, PA 1 2nd Ave SW Glen Burnie, MD 21061 M01220 23a. Part 1. Enter the disease, or co plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final ALLYMMA Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami -transit To the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last burial physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 as t IF FEMALE for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Pregnant at time of death 2 No g Unknown Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 1 Yes 2 No 3 Probably 4 Unknown Completed 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has bade 1 ☐ Yes 2 ☐ No Yes Be 25. Was case referred to medica 26. Place of Death (Check only one) Hospital 2 (No Other: 1 Tyes ER/Outpatient 3 DQA |은 1 Inpatient 2 🗆 4 Nursing Home 5 Residence 6 Other (Specify) After this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 Yes 2 No Natural 5 Pending injury Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 10 84 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CONIZIL WASHINGTON ALTIMONE MEDI CITL 31. Date filed (Month, Day, Year, 32. Registrar's Signature State 282011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ helma 18 201°1 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Medical Anne Arundel Center Annapolis Anne Arundel . Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🔀 F 0 ^{Month}, 8^{ay,} 1^{eg} 27 **Director** 215 24 1407 84 Usual Residence of Decedent or 28a-f shov permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🔀 No MD Anne Arundel Pasadena 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 238 Asbury Road 21122 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Home Maker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Albert Hasloop Bessie Klien 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Kerr - Daughter Wendover Rd Pasadena, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/21/11 | Bayview Crematory Baltimore, 21. Signature of Un Service Licensee 22. Name and Address of Facility GJ Gonce Funeral Home 169 Riviera Drive Pasadena, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ truct Due to (or as a consequence of) disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Exami resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed Yes death? 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of of tifier 29c. License number 024804 07-18-2011 ne and address of person who completed cause of death (Item 23a) (Type, Print) Robert Peterson, MD2001 Medical Parkway Annapolis, MD 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

			Please Type or Print in Blac amend#10aperfng91 State of Maryland 7 D	Cindelible Ink. Ensure	All Copies Ar	e Legible.
		_		Certificate of Death	Reg. N	2011 21.056
	ysicia		1. Decedent's Name (First, Middle, Last) Henry Knight		2. Date of Death Month TUY 24	Oay Year 3. Time of Death
The state of the s	Medic xamin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		c. County of Death
	neral		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	Months Days Hours Min	8. Date of Birth	9. Birthplace (State or Foreign Country)
	ector		Usual Residence of Decedent	s.	Month Day, Year)	
faryland	sa-r sno	Director	10a. State 10b. County 10c. City, Town of 14	or Location		10d. Inside City Limits 1 ✓ Yes 2 ☐ No
ith the N	t be no		10e. Street and Number 437 N. Lakewood Ave	10f. Zip Code	10g. C	Citizen of What Country?
death w	ner mus	-	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
21215-0036 within 72 hours after death with the Maryland given.	Exami	ted by	1 Never Married 2 Married 1 Ves 2 No If Yes, Give Year or Dates.	1 Yes 2 No Specify:		Specify: Black
21215-0036 within 72 hours after giene.	Medica	Completed	(Specify only highest grade completed)	Decedent's Usual Occupation Give kind of work done during most of work fe. DO NOT use retired)	ing 16b.	Kind of Business Industry
d 212 ed within Hygiene.	ant, the	ou l	17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle, Maide	owselor n Surname)
Maryland 2 should be filed it and Mental Hy	atic eve	ם	Henry Knight	Eve	1426	Dilliams
e, Maryl and 2 should Health and Me	r traum		19a. Informant's Name/Relationship (Type-Park) (Type-Park)	Mailing Address (Street and Number or Rur	al Route Number, City o	or Town, State, Zip Code 2 224
altimore, rmit. Page 1 and spartment of Hea	or othe	ı	Burial 2 Cremation 3 Removal from State	Disposition (Name of crematory or other place)	Date 20c.	Location - City or Town, State
Baltimo	important: I nem 2/1 is marked other than "hattlar", or nems 2/3 or 2/2/3-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	2 to and dree of Facility	oo are ten	salto.MI) Neral Service
n §25	6 20		23a. Part 1. Enter the disease, or complications that caused the death. Do no	t enter the mode of dying, sich as cardiac	or respiratory arrest,	Approximate
Pitysi			shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or conditiona	er		Interval Between Onset and Death
	dical niner		resulting in death) Due to (or as a consequence of)			
₽ Pe	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (bisease or mijury	:		
e executed	: · E		that initiated events resulting in death) Last C. Due to (or as a consequence of)	:		
8760 ificate b	as the b	Medic	d			
Box 68760 steath certificate buttending physic	for use	~ I	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
O. But the de	etached		g Unknown Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I	23a Did tabassa	o use contribute to the cause of death?
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending physicil	nld be d	ed by	The state of the s	and and anything decode grown in a care		2 No 3 Probably 4 Unknown
ecor e law rec	ge 2 sho	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
tal R o sian: The ertificate	ctor, pag		25. Was case referred to medical examiner?	26. Place of Death (Chec	1 Yes 2 1	No 1 Yes 2 No
of Vil g Physic er this co	eral dire	욘	1 ☐ Yes 2 ☐ No ☐ No ☐ 1 ☐ Inpatient 2 ☐ ER/Outs 27. Manner of Death	ne of 28c. Injury at	ome 5 Residence 28d. Describe how inju	
sion ttendin death.	the fun	Certificate:	1 Avatural 5 Pending (Month, Day, Year) inju 2 Accident Investigation 3 Suicide 6 Could not be	M 1 ☐ Yes 2 ☐ No	29f Location (Street a	and Number or Rural Route Number,
Divi; ital or A ırs after ral Direc	lled in by		4 D Hornicide determined building, etc. (Specify)		City or Town, Stat	te)
he Hosp in 24 hol ne Fune	pleted fi	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, defended in the control of the basis of examination and/or in the control of the best of my knowledge, defended in the control of the best of my knowledge, defended in the control of the best of my knowledge, defended in the control of the best of my knowledge, defended in the control of the best of my knowledge, defended in the control of the best of my knowledge, defended in the control of the best of my knowledge, defended in the control of the best of my knowledge, defended in the control of the best of my knowledge, defended in the control of the best of my knowledge, defended in the control of the best of my knowledge, defended in the control of the best of my knowledge, defended in the control of the best of my knowledge, defended in the control of the best of my knowledge, defended in the control of the best of my knowledge, defended in the control of the best of my knowledge, defended in the control of the best of my knowledge, defended in the control of the best of my knowledge, defended in the control of the best of my knowledge in the control of the best of my knowledge in the control of the best of my knowledge in the control of the best of my knowledge in the control of the best of my knowledge in the control of the best of my knowledge in the control of the best of my knowledge in the control of the best of my knowledge in the control of the best of my knowledge in the control of the control of the best of my knowledge in the control of the best of my knowledge in the control of the control of the best of my knowledge in the control of the cont	nvestigation, in my opinion, death occurred a	t the time, date and place	ce, and due to the cause(s) and manner stated.
To the with To the	CO		29b. Signature and title of certifier 15 Ryap aml M.D.	29c. License number	. 1	Date signed (Month, Day, Year)
	3		30. Name and address of person who completed cause of death (Item 23a) (Ty			timore MD 21709
	Stat	e	31. Date filed (Month, Day, Year) 32. Registrar's Signature		۱۱۹۱۱ د.	
Re	gistra	ır	JUL 28 2011 June B. Jak			

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.
Amend 23a per med cert G92/ Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Reg. No. (Registra 1. Decedent's Name (First, Middle, Last) 2. Date of Death Alphonso Physician/ Month Knight 3:00 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b, City, Town, or Location of Death 4c. County of Death Genesis Randallstown <u>Randallstown</u> <u>Baltimore</u> If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs, last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 57766752 1 🖬 M 2 🗆 F Months Davs Hours Min. (Month, Day, Year) 8/3/48 Mary land Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item marked other than "natural". 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 Yes 2 No MD Gaithersburg Montgomery 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 9649 Horizon Run Rd 20886 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married If Yes, Give 1 Yes 2 No Specify 3 Divorced Specify Year or Dates Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Laborer Mechanical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ unknown unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Terry Sullivan / Guardian</u> Calvert St. Suite 200 Baltimore, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1

■ Burial 2

□ Cremation 3

□ Removal from State St. Stanislaus Ceme. 4 Donation 5 Other (Specify) 7/11/11 Baltimore, Maryland 22. Name and Address of Facility Loudon Park Funeral Rome 21. Signature of Euperal Service Licen 3620 Wilkens Ave. Baltimore, maryland 21229 4 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ph_sician/ Due to (or as a consequence of): Medical Examiner Myocardial infarction w/history of Coronary Art. Securatelly list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed <u>Seizure Disorder</u> signed by the attending physician and deed detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Psychosis Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Dav Year Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an sate has page 2 s autopsy perform rmed? this certificate 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical uneral director, Be 26. Place of Death (Check only one) examiner? 2 No Hospital: Other: ဂ္ 1 Inpatient 2 I ER/Outpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred / fter 10 Natural 5 Pending work? 1 🗌 Yes 2 🗌 No neral Director: / Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner Dn the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Fractioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie DOO 69295 30. Name and address of pe who completed cause of death (Item 23a) (Type, Print) undor 358 MOCUBBLAY ANCH LORFOLK 23507 egistrar's Signatu State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 24058 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Ones Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Emerald Estate Assisted LIVIN Timove 7. Age (In yrs. last birthday) Yrs. If Under 1 Year 8. Date of Birth (Month, Day, **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 F Director Ven (Usual Residence of Decedent 28a-f shov 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director timore 1 Yes 2 ☐ No 5 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21218 USA items Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☐ No Black, White, etc. "natural", or Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes No Specify: If Yes Give Specify: 3 Widowed 4 □ Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) eacho Be 17. Father's Name (First, Middle, Last) ည owes . Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 NetHod of Disposition

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State injury or Signature of Fune al rvice Lio nsee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying Part 1. Enter the disease, or complications that vacces shock, or heart failure. List only one cause on each line Approximate Interval Between Immediate Cause (Final Onset and Death fancreatic Cancer Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner if any, leading to immediate Due to (or as a consequence of): Cause (Disease or linjury the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical that the death certificate be IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ Day Year Pregnant at time of death 9 Unknown 9 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by disease antem Division of Vital Records, 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director; After this certificate has completed filled in by the funeral director, page 2: autopsy performed? 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: Certificate: To 1 Tes 2 100 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Mann of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 atural 5 \square Pending 1 Yes Accident Investigation Suicide 6 Could not be 3 ☐ Sulcide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) bredere #27 21215 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #1, per MD G917 7/29/11 TT

Amend #1, per MD G917 7/29/11 TT

Of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. NZ Certificate of Death 1. Decedent's Name (First, Middle, Last) Minnie Lipsitz AKA Bonnie Lipsitz 2. Date of Death Day **Physician** 09:30 AM 2011 07 5 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** LEVINDALE HEBREW HOME BALTIMORE N/A If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Funeral Months Days Hours 1 M 2 7 Director 96 09/30/1914 218-58-4494 MD Usual Residence of Decedent 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits rai", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 X No Director MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2528 SUMMERSON ROAD 21209 USA Funeral filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 🗓 No Specify: Specify: þ 3 X Widowed 4 ☐ Divorced WHITE Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be pe permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any InJury or other traumatic ev FINKELSTEIN FANNIE ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CAROLE KANEFSKY / DAUGHTER 6918 BLANCHE ROAD, BALTIMORE, MD 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD FRIEDEL LODGE 07/27/2011 ROSEDALE, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ONGESTIVE HEART /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) ed by the detached 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ MENTIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performed death? 1 ☐ Yes 2 ☐ No 2 No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No To the Hospital or Attend within 24 hours after death To the Funeral Director: 2 Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) PHYSICIAN DO064533 07-25-2011

State Registrar

DHMH 17 Rev 1/2001

BABATUNDE 31. Date filed (Month, Day, Year) AJANI 32. Registrar's Signature

JUL 28 2014 Gener S. Spark

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LEVINDITE CELIATIC

2434

W. BELVEDERE

AVE. BALTIMORE MD

21215

arjorie L. McK	enzi	1- For State Registrar	•	ment of He ficate of De		tal Hygie		g. No. 2	2011	24060
Physici ledical Exami		Decedent's Name (First, Middle, Last) Marjorie	Lynn McK	enzie		M	ate of Deatl onth ly 24, 20	Day	Year	3. Time of Death 1830 hrs
		4a. Facility Name (if not institution, give street and number)		ity, Town, or Location of		iy 24, 20		ounty of Death	1
Formeral		3132 Keswick Road 5. Social Security Number 6. Sex 7. Ag	ge (In yrs. last		altimore Under 1 Year If Unde	r 24Hrs. 8.	Date of Birt		V/A	thplace (State or
Funeral Director		216-72-4974 1_M 2\hat{X}F	54 		onths Days Hours	1 3 44	ept 17		Fornic	untry) MD
any		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Location						10d. Inside City Limits
faryland 28a-f show at once.	or	MD N/A	Balt	imore						1 YY Yes 2 No
th the Maryland 23a or 28a-f sho notified at once	Director	10e. Street and Number 3132 Keswick Road		10f	Zip Code 21211		10	g. Citizen	of What Cou	ntry?
death with or items 23	Funeral	11. Marital Status 1 Whever Married 2 Married Armed Forces 1 Yes 2			cedent of Hispanic Orig pecify Cuban, Mexican,				White, etc.	can Indian, Black,
s after ural", o	Ď	3 Widowed 4 Divorced If Yes, Give Year or Dates:		1 Yes		almad military and a second	1		whi.	
2 hour	eted	15. Decedent's Education (Specify only highest grade cor Elementary/Secondary (0-12) College (1-4 or			sual Occupation (Give k f working life. DO NOT		one	166. Kind	of Business/I	ndustry
036 vithin 7 ene. er than Medica	Completed	12th		Telephone	Operator				neral H	ospital
:15-C	Be Co	17. Father's Name (First, Middle, Last) Joseph J. McKenzie				s Name (First othy F .			name)	
212 ould be d Ment s mark	To B	19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Add	ress (Street and Num				r Town, State	, Zip Code)
MD and 2 sh salth an		Joseph McKenzie (Brother) 20a Method of Disposition	20h Blad		Terrace Bal (Name of cemetery,	to, MD		200 100	ation - City or	Town State
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Sel and Mental Hygiene. Importance: If item 71 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once.		1 Burial 2 Cremation 3 Removal from St 4 Donation 5 Qther Specify:	ote crer	matory or other pl ntic Crema	ace) tory	07/26	/11	Glen	Burnie	,
Ball permit Depart Impor		21. Signature of Funeral Se, 152 Licensee		Burgee	and Address of Facility Henss-Seitz alls Road Ba	Funeral	Home,	Inc.		
Physician		23a. Part I. Enter the disease, or complications that caused failure. List only one cause on each line.	the death. Do	o not enter the mo	atts Koad Ba ode of dying, such as ca	LEO, MD ardiac or resp	iratory arre	st, shock,	or heart	Approximate Interval Between Onset and
/Medical Examiner	1	Immediate Cause (Final disease a. Atherosclerotic		cular Diseas	e					Death
		or condition resulting in death) Due to (or as a cons Sequentially list conditions, b.	equence or):							
	iner	if any, leading to immediate Cause Enter Underlying Cause	equence of):							
cuted nnd transit	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a cons d.	equence of):							
an a	edical	UNPENDED AMENDED								
3760 ficate b g physi s the bu		IF FEMALE: 23c. If yes, outcome the light of	me of pregnan		eath 3 Ectopic	pregnancy		23d. Da Mor	ate of delivery	y Day Year
Box 68760, e death certificate be the attending physic of for use as the burn	iciar	past 12 months?	time of death	2 Fetal de 5 Other (pregnancy		IVIO	idi L	oay real
	Physician/N		h but not resu	lting in the under	ying cause given in Par	et. [2	23e. Did tob	acco use	contribute to	the cause of death?
ires that the signed by the detach	Ď	Schizophrenia			, g g					ably 4 🗹 Unknown
ords, w requires been a should	ete						24a. Was a autops			topsy findings available ompletion of cause of
Recc The lav cate has	Completed						perforr Yes 2	ned?	death? 1 ✔ Ye	
tal Recision: The certificate rector, page	Be	25. Was case referred to medical examiner?			26.Place of Death (<u> </u>		- []	
of Vig R Physical the Physical direction	L.	1 Yes 2 No Inpatte 27. Manner of Death 28a. Date of Inju	ıry 28	R/Outpatient 3 Bb. Time of Injury	DOA Outer 4 28c. Injury at Work?	Nursing Hon 28d.	Describe h		6 ✔ Other	Scene
ion tendin eath.	ation	1 V Natural 5 Pending 2 Accident Investigation (Month, Day, Y	(ear)		1 Yes 2	No				
Division of Vital Records, piral or Attending Physician: The law requirements of earth. For I Director. After this certificate has been silled in by the funeral director, page 2 should the control of the funeral director.	Certification:		njury - At home	e, farm, street, fac	tory, office building, etc		ocation (Si or Town, St		lumber or Ru	ral Route Number, City
To the Hospital or within 24 hours after To the Fuoeral Discompletely filled in	Medical (29a. Certifier 1 Certifying Physician: To the best of m (Check only one) 2 Medical Examiner: On the basis of examiner and manner stated.	y knowledge, mination and/	death occurred a or investigation, in	t the time, date and place or my opinion, death occ	ce, and due to	o the cause ime, date a	e(s) and ma nd place, a	anner as state and due to the	ed. e cause(s)
	ž	29b. Signature and time of certifier			29c. License number O.C.M.E.			29d. Date July 25		oth, Day,Year)
2		30. Name and address of person who completed cause of o Melissa Brassell, MD Assistant Medica			altimore Street, Ba	altimore, M	ID 2122	3		
St Regist	ate	31. Date filed (Month, Day, Year) 32. Registra	r's Signature	(1) (2) (2)						
DHMH 17 Rev 1/2		OCME S.	grace	ORIGINAL				-		

ORIGINAL

21			For State Registrar		larylan		artment of I		and Mental	Hygiei Reg.	2011	24061
	Physicia Medic		1. Decedent's Name (First, Middle, L Bartholomew F.	X. O'Brien					2. Date of Month	of Death	23, 2011	3. Time of Death 7:45P M
	Examir	ner	4a. Facility Name (if not institution, gi	Medical C			4b. City, Town, c	Tows	son		4c. County of Dea Baltin	ath none
	Funeral Director				ge (In yrs. Ia 85	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours		of Birth h, Day, Yea 17 19	9. B 926 N.	irthplace (State or Foreign ountry) J
	Maryland 28a-f show otified at	Director	10a. State 10b. County MD Baltim	ore		, Town or Loc	cation					10d. Inside City Limits 1 ☐ Yes 2 🏋 No
	n with the is 23a or and inst be no	Funeral D	10e. Street and Number 18 Rainflower P	ath #202			10f. Zip Code	1152			Citizen of What C	country?
9600	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amportant: If item 27 is marked other than "hatural", or items 23a or 28a-f show amportant: If item 27 is marked other than "natural", or items 23a or 28a-f show amportant: If item 27 is marked other than "natural", or items 23a or 28a-f show amportant in the Medical Examiner must be notified at once.	Ď	11. Marital Status 1 ☐ Never Married 2 ▼Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent I Armed Forces? 1 X Yes 2 I If Yes, Give Year or Dates.			Vas Decedent of H Yes, specify Cuba		in? (Specify Yes or Puerto Rican, etc.	No-	14. Race - Am Black, Whi Specify: W	te, etc.
1215-	ithin 72 ho ene. r than "nat	Completed	15. Decedent's (Specify only highest to Elementary/Seconday (0-12)	Education grade completed) College (1-4 or 5	5+)	(Give F life. DC	ent's Usual Occup kind of work done O NOT use retired)	during most o	5		. Kind of Business	
Baltimore, Maryland 21215-0036	d be filed w Mental Hygi urked othe	To Be	17. Father's Name (First, Middle, Last Bart O'Brien	<u>.</u>		BIII	oping G	18. Mother	's Name (First, Mic nces Bra	ddle, Maide		orwarding
, Man	nd 2 shoul ealth and i m 27 is ma		19a. Informant's Name/Relationship Joan O'Brien/wif			19b. Mailin 18 Ra	g Address (Street inflower	and Number Path	or Rural Route Nu #202, Sp	mber, City arks	or Town, State, Z MD 211	ip Code) 52
timore	t. Page 1 a tment of H tant: If ite jury or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Special Control of the Control	☐ Removal from State cify)	CE	emetery, crem arriso		Veter	7/29/11 ans Cem.	Gan		orest, MD
Ba	permit Depar Impor any in			Gee Dagle	_	Le 1	Name and Addre mmon Fun O W. Pad	ss of Facility eral H onia R	lome of D	ulane nium	y Valle MD 210	y, Inc.
~	h sician/ Medical	9 14	23a. Part 1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. ASPIRA	TION	PNEU		g, such as ca	ardiac or respirato	ry arrest,	Á	Approximate Interval Between Onset and Death WEEKS
كمه	Examiner	er	Sequentially list conditions,	Due to (or as a RESPIR	RATOR	RY FAI	LURE					4 DAYS
	te be executed nysician and he burial-transit	al Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	c. HEART Due to (or as a	FAIL	.URE						S MEEKS
68760	rtificate b ing physic e as the b	/Medical	IF FEMALE:	d							<u> </u>	
P.O. Box (To the troughtal of Attending Physician: The law requires that the death certificate be executed within 24 hours after death a star death. To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant at 9 Unknown	2 Fetal	death 3 🗌	Ectopic pregnand Other (specify)	БУ		_	23d. Date of de Month	elivery Day Year
ds, P.C	quires that en signed k ould be det	ا۾	Part II. Other significant conditions CORONARY HE	1-		ilting in the ur	nderlying cause giv	en in Part I.				o the cause of death? Probably 4 🗆 Unknown
Division of Vital Records,	sıcıan: The law re certificate has be irector, page 2 sh	Completed							— I а	Vas an autopsy performed Yes 2	prior to	utopsy findings available completion of cause of s
/Ital	sician s certifi lirector	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ※ No	Hospital:			C41-	ar-	(Check only one)			
6	ng Phy ter this neral c		27. Manner of Death	28a. Date of Injur (Month, Day	ry 2	R/Outpatient 28b. Time of injury	28c. Injury	4 ∐ Nurs ⁄at	sing Home 5 🗆 F 28d. Descri		6 Other (Speciary occurred	cify)
ion	ttendii death. stor: Ai / the fu	Certificate:	1 Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not	on be				f Yes 2□N	lo			
	spiral or A ours after eral Direc filled in by		4 Homicide determined	building, etc	. (Specify)				City or	Town, Sta	ite)	ıral Route Number,
'	thin 24 h the Fun the Fun mpleted	Medical	(Check 2 Medical Examonly one) 3 Certifying Nu	ysician: To the best of r niner: On the basis of ex rse Practioner: To the b	camination :	and/or investig	gation, in my opinio	n, death occu e time, date a	urred at the time id:	ate and pla	ce and due to the	cause(s) and manner stated
	₽ № ₽ 00		29b. Signature and title of certifier	adlor	·N	0	29c. License	number 59711			Date signed (Mont	
(D.O.		30. Name and address of person who					10000	MANA	.17"	04002	
	State Registra	~	LINDA ADLER, M B1. Date filed (Month, Day, Year)	32. Registral			IVE IU	WOUN,	MARYLAI	ИŊ	21204	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 25,27,28a-f per me,g917,07/28/2011dhb

Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2011 Oleszczuk, Jr. Joseph Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death AKNE Himore Washington Medical Center 6 len Buenie ARUNDEL If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F (Month, Day, Year) 04/28/1944 Director 215-40-1100 67 MD Usual Residence of Decedent shov 10a, State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland at Completed by Funeral Director 10d. Inside City Limits 3a or 28a-f sh t be notified a 1 🗆 Yes 2 🗓 No MD Anne Arundel Crownsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a Examiner must 624 Cedarwood Lane 21032 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 🗓 No Specify: Specify: 3 Widowed 4 Divorced White other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Sales Insurance 12 To Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) pe Oleszczuk, Sr. Joseph J. Rita Anna Wiesnieski Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Heath ar. Important: If item 27 is any injury or other trau once. Crownsville, MD 21032 624 Cedarwood Lane Mrs. Linda Oleszczuk / Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State MD Veterans Cemetery: 06/07/2011 Donation 5 Other (Specify) Crownsville, MD Signature of Funeral Service Licensee 22. Name and Address of Facility 1 2nd Avenue SW Glen Burnie, MD Singleton Funeral & Cremation Services, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Fhysician/ disease or condition resulting in death) FATTE CARDIAC Medical Due to (or as a consequence of): Examiner ASPHYXIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) F FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month 4 Pregnant at time of death g Unknown signed by the a g 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown After this certificate has been si funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy performed 1 Yes 2 No 1 Ves 2 🖵 No Be 25. Was case referred to predical 26. Place of Death (Check only one) examiner? Other: 은 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Subject choked 05/29/2011 . **H**atural 5 Pending 7:10p. M Accident on bolus of food. 1 ☐ Yes 2 🗶 No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 624 Cedarwood Lane Crownsville, MD determined building, etc. (Specify) within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 1211 of person who completed cause of death (Item 23a) (Type, Print) corner. MoDian AZIMONO WAS 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

JUN 0 7 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month July Day John Anthony Reymann 25, 2011 Medical 1:40 P. 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice of Howard Co. Columbia Howard If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 ÅM 2 □ F Year 1927 Months June 13, 84 Director 219-22-9630 Maryland Usual Residence of Decedent or 28a-f show notified at 10b. County filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location Director 10d. Inside City Limits MD Baltimore 1 Yes 2 X No Halethorpe ō 10e. Street and Numbe 10f. Zip Code "natural", or items 23a or idical Examiner must be r 10g. Citizen of What Country? Funeral 1811 Palo Circle 21227 USA 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Armed Forces' þ 1 Never Married 2 X Married 1 X Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White Completed 3 Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) the Auto Mechanic Automobile Be 17. Father's Name (First, Middle, Last) e 1 and 2 should be filed of Health and Mental H item 27 is marked ot rother traumatic ever 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Hildebert Reymann Helen Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other the Bernadette Reymann 1811 Palo Circle; Halethorpe, MD 21227 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 1 Burial 2 Cremation 3 Removal from State New Cathedral Cemetery 7/28/2011 4 Donation 5 Other (Specify) Baltimore, MD Sterling Ashton Schwab Witzke 21. Si nati re of Funeral Service 22. Name and Address of Facility Sterling Ashton Sc Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of): To the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Month Day Year 2 No signed by the a d be detached f Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DIABETES 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown CORONARY ARTERY DISEASE Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? Yes 2 No death? After this certificate 2 🗌 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 🗷 No Hospital Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🔀 Other (Specify) Manner of Death 28a. Date of injury 1 Natural 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 5 Pending Accident Investigation 1 Yes 2 No Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) JULY 25, 2011 6+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6336 DEDAR LANE COLUMBIA, MO 21044 DOBERMAN, MO DANIEUE

Registrar
DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year

282011

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Schwart Z 2 Z Day Month Year Dorothy 6:15P M JULY Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Northwest Hospital-Seasons Hospice Randallstown Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Dec. 14, 1920 1 🗆 M 2 🖾 Days 90 **Director** 216-18-3973 Maryland Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director ms 23a or 28a-f s must be notified 1 🗌 Yes 2 😾 No MDBaltimore Reisterstown 10e. Street and Number 10a. Citizen of What Country? Funeral 319 W. Cherryhill Court USA 21136 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. ö Completed by 1 Never Married 2 Married 1 Yes 2 🔀 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White "natural", 3 X Widowed 4 Divorced Year or Dates ed other than "natu event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Mental Hygiene. Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) f Health and Mental Fitem 27 is marked oother traumatic eve ပ Robert Zittinger Marie Horn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
319 W. Cherryhill Court; Reisterstown, MD 21136 Donald Schwartz Son item 2 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important: If it any injury or o cemetery, crematory or other place)
Baltimore Wash.Crem. 1 Burial 2 X Cremation 3 Removal from State 7/28/2011 Laurel, MD ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 Signature of Funeral Service Licer Jours 23a. Part 1. Enter the disease, or implications that cause 1 the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Atheroscientic Cardiovascular Disease disease or condition Medical resulting in death) Due to (or as a consequence of). Examiner Sequentially list conditions, it any, leading to incredicts cause. Enter Underlying Examine Due to (or as a consequence or Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed After this certificate has been significate has been significated and alterector, page 2 should . Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☑ No Other: 6 Dother Specify) hispice မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manper of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at al or Attending P s after death. I Director: After t Certificate: 28d. Describe how injury occurred 1 🗹 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f, Location (Street and Number or Rural Route Number, determined

Box 68760 P.O. Division of Vital Records,

DHMH 17 Rev 7/2009

Registrar

Medical

(Check

29b. Signature and title of certifier

filed (Month, Day, JUL 28 2011

US kinjapamen D

N 5 Rajapakte, M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2835 SMITH

32. Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated for this name of the country in the country in

D0057465

5-203

29c. License number

29d. Date signed (Month, Day, Year)

B4 17 more MD 21209

7/24/11

		For State	State of Mary		artment of Hea tificate of Dea		, ,		
		Registrar 1. Decedent's Name (First, Middle,		-	tineate of Bot	2	Reg. I Date of Death	2011	2 4 0 6 5
Physicia Medi		Joan. L.	Crocker -	Spence			Month	25 2011	
Examir	ner	4a. Facility Name (if not institution, Union Menorial	give street and number)		4b. City, Town, or Low Balliniane	cation of Death	(Galtiware	
Funeral				yrs. last birthday)	If Under 1 Year If	Under 24 Hrs. 8.	Date of Birth	9. Bir	thplace (State or Foreign
Director	ı	Usual Residence of Decedent	1 L W 2 A F	50 Yrs.			(Month Day, Year 06/27/19	6/	untry) MD
yland f shov ed at	향	10a. State 10b. County	100	c. City, Town or Loc					10d. Inside City Limits
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21215-0036 within 72 hours after death with the Maryland giene. et than "natural", or items 23a or 28a-f sho t, the Medical Examiner must be notified at	by Funeral Director		y Avenue		2/2/	13	Tog.	USA	outing:
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21215-0036 within 72 hours after gjene. er than "natural", o , the Medical Exam	ed b	1 Never Married 2 Marri 3 Widowed 4 Divorced	ed 1 ∐ Yes 2 No If Yes, Give Year or Dates.	1	☐ Yes 2 No S	Specify;		Specify: B	CLACK
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	16	ANTOINE D. S	PENCE SPOUS	se 3918					
Baltimore, Dermit. Page 1 and Department of Heal mportant: If item 3 any injury or other		20a. Method of Disposition 1 Burial 2 □ Cremation	3 Removal from State	Ob. Place of Dispos cemetery, crem	sition (Name of natory or other place)	Ø /a /	20c.	Location - City or	
Baltimol permit. Page 1 Department of Important: If is any injury or of		4 Donation 5 Other (St	necify)	ARRISON					ECAL SERVICES
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Of \ ng Phy ter this neral d	ite: To	27. Manner of Death 1 ✓ Natural 5 Pending	28a. Date of injury	28b. Time of	28c. Injury at work?	4 Nursing Home 28d	. Describe how inj		erry)
SION ttendir death. stor: Af	Certificate	2 Accident Investiga 3 Suicide 6 Could n	ation		M 1 ☐ Yes	2 🗆 No	1		and Davids Alexandra
DIVISION Of VITAI RECORDS, pital or Attending Physician: The law requires ours after death. eral Director: After this certificate has been signified in by the funeral director, page 2 should be		4 ∐ Homicide determir	building, etc. (Sp		set, ractory, office	201.	City or Town, Sta		ral Route Number,
ie e e	edical	(Check 2 Medical Ex	Physician: To the best of my kaminer: On the basis of examin	nation and/or investi	igation, in my opinion, d	death occurred at the	time, date and pla	ce, and due to the	cause(s) and manner stated.
To the Hos within 24 h To the Fun completed	Š	only one) 3 \square Certifying I 29b. Signature and title of certifier	Nurse Practioner: To the best	of my knowledge, d	29c. License nui	mber	29d. [e(s) and manner as Date signed (Mont	
		►C/41274	to MD UM	laryland f	M Resilent	AT 243894	b 7	125/201	١
3		30. Name and address of person w			rint) aca Street	Sail.	MN 21	201	
Stat	e	31. Date filed (Month, Day, Year) JUL 2 8 2011	32. Registrar's S	ignature	acut street	Beilline	reg 21	201	
Registra	ar	JUL 2 8 2011	Cenara B.	garker	:c				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 24066 State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year 157 PM Vincent E. Tomalavage 1105 JUN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** AGNES HOSPITA BALTIMORE If Under 24 Hrs. Social Security Numbe Age (In vrs. last birthday) 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ፟፟ M 2 ☐ F Months Hours July 3, 1922 89 Pennsylvania 188-12-1767 Director Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director injury or other traumatic event, the Medical Examiner must be notified or 28a-f 1 ☐ Yes 2 🖾 No Catonsville Baltimore 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a 21228 USA 5713 Edmondson Avenue Apt TA2 "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc þ 1 X Never Married 2 Married 1 Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify. Specify 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Dry Dock Worker Ship Yard Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clement Tomalavage Anna Weiss 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important; If item 27 is any injury or other tra 724 Shawtown Road; Glade Valley, NC 28627 Sharon Tomalavage 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 A Cremation 3 Removal from State 4 Donation 5 Other (Specify) 7/26/2011 Atlantic Crematory Glen Burnie, MD 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. . Signature of Funeral Service Lice 1596 630 Edmondson Avenue: Catonsville 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Phainozulorax 4 DAYS disease or condition Medical resulting in death) Due to (or as a consequence of Examiner EMPHISEMA Sequentially list conditions, Examine pue to for as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury burial-transi WITH EXECTION FLAKTION 15-20 ISCHEMIC CARDIOMY OPATHY that initiated events Due to (or as a consequence of). resulting in death) Last Physician/Medical the attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an CHIONIC IZENAL INSUFFICIEN autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: ျ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death

P.0. Records. Hospital or Attending Physician: The law Division of Vital

TOMACAVACE To the Hospital or Attending within 24 hours after death.

To the Funeral Director, After completed filled in by the fun. State Registrar

Certificate:

Medical

1 Natural

2 Accident
3 Suicide
4 Homicide

rilly one

29a. Certifier (Check

Date of injury (Month, Day, Year) 5 Pending Investigation 6 Could not be determined

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at work? 1 ☐ Yes 2 ☐ No

Gorfflying Nurse Precitioner To the Sent of my knowledge. Settle construct at the time, date and place, and due to the cresself) and manner as state

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

21229

dD.	Sig	nature	and	title of C	ermer			
		-	0	U	>	,	m	Γ

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

900 CARON AVENUE BALTIMORE WANA AISA SAAH 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month JUAID PAMOHT Juli 5:48 PM 2011 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** 4c. County of Death ANNE ARundel Baltimore Washington Medical Center Glen Burnie If Under 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours 1 - M 2 X F Director 219-52-3592 24 48 MD Usual Residence of Decedent 28a-f shov 10a. State with the Maryland other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Glen Burnie MD Anne Arundel , JO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a U.S.A. 21061 404 Lincoln Drive items filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married "natural", or 1 ☐ Yes 2 😾 No Specify. Specify: Black 3X Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Anne Arundel Co. Elementary/Seconday (0-12) College (1-4 or 5+) Custodian Public Schools 12th grade Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental I Important: If item 27 is marked of any injury or other traumatic eve ည should be Mary Hudson George Lee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Md 21108 Page 1 and 2 8225 Millfield Ct., Millersville, Shirldene Bethea-Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/1/2011 Woodlawn, Memorial Park Sig sture uneral Service Licon 22. Name and Address of Facility Macch F/H West 4306 Nabash Ave, Baltimore, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) PULMONARY EMBOU 2PAQ 3 Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 🔀 No Dav Year 5 Other (specify) Pregnant at time of death 1 Yes 2 9 Unknown the 9 Hinknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by RECORDE CERUTEUR HORF DUICESUB JAHIMOCER-ARTHI 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown neec 24b. Were autopsy findings available 24a Was an After this certificate has I prior to completion of cause of death? performe 2 X No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: ည 1 🗌 Yes 2 🔀 No 1 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) M Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No within 24 hours after death

To the Funeral Director: /
completed filled in by the f Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

gur

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State Registrar GUILLEAMOJOSE 2011

Parisones des crandoca

29b. Signature and title of certifie

BOI HOSPITAL DRIVE, ELEN BURNIE, HD ZOIGI rank

completed cause of death (Item 23a) (Type, Print)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D0065711A

29d. Date signed (Month, Day, Year)

2014 54, 5011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day White **Physician** Charles 2011 6 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Center Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6 Sex **Funeral** 1 XM 2 □ F 55 Yrs. 1955 Director Maryland 213-68-8791 Sept 4. Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Items 23a or 28a-f sho ler must be notified at 1 ☐ Yes 2X No Director Baltimore Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 473 Mirabile Lane Funeral USA death 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No 1975 If Yes, Give Year or Dates: 1979 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Examiner Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married altimore, Maryland 21215-0036 ö by 1 ☐ Yes 2 XNo Specify: White 3 ☐ Widowed 4 X Divorced 1979 "naturai", Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Truck Driver Oil Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ith and Mental F 27 is marked of traumatic even ည <u>William D. White</u> <u> Gladys_Nuedling</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a I: if item 27 is / or other trau 2240 Whiteford Road Whiteford, Maryland 21160
te of Disposition (Name of Date 20c. Location - City or Town, State Deborah Ann Ross, Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department o Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 07/27/11 Baltimore, Maryland 21. Signature of Funeral Service License Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryl Thomas Gregor 23a. Part 1. Enter the disease, or complice shock, or heart failure. List only on Maryland 21228 Approximate Interval Between Onset and Death ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Myocardial Infarction Immediate Cause (Final **Physician** Acute disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated expert) Examine Due to (or as a consequence of) The law requires that the death certificate be executed nding physician and use as the burial-tran that initiated events Due to (or as a consequence of) Obivision of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy in the past 12 months? Month 5 Other (specify) signed by the at 1 Yes 2 9 Unknown 2 □ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Hyperther Mia 1 Tyes 2 No 3 Probably 4 Junknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has 2 No 2 No 1 Yes 1 Tyes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☑Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) ၉ s after death.
I Director: After this of in by the funeral d 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: I or Attending F after death. 5 Pending investigation Injury 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide To the Hospital of within 24 hours a To the Funeral D 29a. Certifier 1 (Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated_ 29d. Date signed (Month, Day, Year) 29b. Signature and title July 26,2011 D 33240 impleted cause of death (item 23a) (Type, Print) 30. Name and address of a 4940 Eastern Avenue, Baltimore, MD, 21224 6 14

DHMH 17 Rev 1/2001 11595

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 23, Day 2011 Viola M. Wheeler 7:15 P.M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Charlestown Care Center Catonsville Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. . Age (In vrs. last birthday 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day, Month: 218-09-2160 91 Maryland **Director** Ĭ919 Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland at 10c City Town or Location 10d. Inside City Limits Director notified 1 🗌 Yes 2 🔀 No MD Baltimore Catonsville 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Examiner must be Funeral 23a 709 Maiden Choice Lane #328 USA items 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 X No
If Yes, Give
Year or Dates. Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White 'natural", 3 № Widowed 4 □ Divorced Specify: Completed event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working than ' life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Hygiene. Clerk Ith and Mental Hygien 27 is marked other the r traumatic event, the Dept of Corrections Be 17, Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ည William A. Atkins and 2 should be Health and Menta Ada Glanville 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Heatth ar Important: If item 27 is any injury or other trau Bonnie Scott Daughter 1232 Poplar Avenue; Baltimore, MD 21227 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 ☐ Donation 5 🖾 Other (Specify) Entombment Lofraine Park 7/27/2011 Woodlawn, Maryland 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 Signature of Pureral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final Onset and Death Physician/ Acute disease or condition Medical resulting in death) **Examiner** ular diseable Sequentially list conditions Examiner If a, y, leading to him rediate cause. Enter Underlying Cause (Disease or linjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Wisibrervital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) 12 months? in the past 12 Month Day Year Pregnant at time of death Yes page 2 should be detached it Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? after death.

Director: After this certificate | 1 🗌 Yes Yes completed filled in by the funeral director. 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospita Other 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier ress of person who completed cause of death (Item 23a) (Type, Print) 1.9 711 Maiden Choice Ln Cataroville MD ieurbarter

State

Registrar

d (Month, Day, Year,

28 2011

32. Registrar's Signatur

			For State Registrar		State	of Ma	aryland		artment rtificate			l Mer		giene Reg. No.	2011	24070
	Dhysisi		1. Decedent's Name	e (First, Middl	e, Last)								Date of Dea Month	Day	Year	3. Time of Death
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	Examin	er	4a. Facility Name (/		. 0	number)					Location of De	ath		4c. (County of Death Baltin	
1			73 Winte			1 - 4	- 0	- 4 5 2 4 5 - 1 - 1			sville	rs o	Data of Birt	h		place (State or Foreign
	Funeral Director		5. Social Security N 213-72-12 Usual Residence of	207	6. Sex 1.237¥M 2□	F	e (in yrs. ia	est birthday) Yrs.		Days	Hours Mi	in.	Date of Birt (Month, Da v • 26	, Year) , 19	Cou	yland
	land ow		10a. State	10b. County			10c. City	, Town or Lo	cation							10d. Inside City Limits
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	or 28	Sire	10e. Street and Nur	nber					10f. Zip (Code					zen of What Cou	ntry?
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36	be filed within 72 hours after death with the Maryland ntal Hygiene. so other than "natural", or items 23a or 28a-f show event, if a Moricol Evani we nut be notified at	by Funeral	11. Marital Status 1 ☑ Never Marri 3 ☐ Widowed		ried Armed	Decedent d Forces? es 2 🔀 , Give or Dates:	Ever in U.S No		Was Decede If Yes, specii 1 X Yes 2		ispanic Origin? n, Mexican, Pu Specify:	(Specify erto Rica	y Yes or No- an, etc.)		14. Race - Ameri Black, White, Specify: Wh	etc.
5-0036	2 hou			15. Deceder	nt's Education		-1	16a. Dece	dent's Usual	Occupa	ation			16b. Kir	nd of Business/Ir	ndustry
Maryland 21215	d within 72 giene. ir than "na	Completed	Elementary/Seco	cify only highe	st grade complet	<i>ed)</i> je (1-4or (5+)	`life.	kind of work DO NOT use todian	retired	during most of w	vorking		Men	tal Hea	1th
P	al Hyger other vent,	Be C	17. Father's Name	(First, Middle,	Last)						18. Mother's N				Surname)	
/aı	uld by Menta arked	၉	John R.	Yutzy	, Sr.						Herlin					
	nd 2 shoulth and 27 is ma		19a. Informant's Na Herlinda			har					_{and Number or} m Squar				r Town, State, Zi 'A 2014	
ē,	s 1 ar if Hee item othe		20a. Method of Dis	position	•		20b. Pl	ace of Dispo	sition (Name	e of	e)	Date		20c. Lo	cation - City or T	own, State
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Baltimore,	permit. Pages 1 and 2 should be file Department of Health and Mental H Important: If item 27 is marked oth any Injury or other traumatic even once.		21. Signature of Fo			^	10105	U F	2. Name and uneral	Addres Ho	ss of Facility Some of Code	ter Cato	ling / nsvil e: Car	Ashto le,	on Schwa Inc. ville, M	ab Witzke AD 21228
4	Physician /Medical Examiner	J.	Immediate Cause disease or condition resulting in death)	rt failure. List (Final on	a. Due	on each li	ne. I q C a consequ	. Do not en	ter the mode	of dyin						Approximate Interval Between Onset and Death
8760,8	cate be executed physician and the burial-transit	dical Examiner	Sequentially list co- if any, leading to im- cause. Enter Unde Cause (Disease or that initiated events resulting in death) I	5	C		a consequ	ence of):								
.O. Box 6	Attending Physician: The law requires that the death certific rdeath. rdeath. ector: After this certificate has been signed by the attending p by the funeral director, page 2 should be detached for use as by	Physician/Medical	IF FEMALE: 23b. Was deceden in the past 12 1 Yes 2 9 Unknown	months? ☐No	1 □ L 4 □ F	ive birth	of pregna 2 ☐ Fetal at time of d	death 3	⊒ Ectopic pr ⊒ Other (spe		у				23d. Date of deli Month	very Day Year
σ.	res that signed I be deta	by P	Part II. Other signif	41	1 /			lting in the u	inderlying ca	use giv	en in Part I.		23e. Did t	obacco u	use contribute to	the cause of death?
ğ	quire en siç uld b	ed t	9/10	012 11	Holera	MLL	CIP.				 -	_	1 🗆 '	Yes 2	□ No 3 □ Pr	obably 4 Unknown
Reco	: The law requii cate has been s page 2 should	Completed													prior to death?	topsy findings available completion of cause of
ta	ician: Th certificate ector, pag		25. Was case refer	red to medica	al .						26. Place of I	Death ((1 □ Yes Check only o		I La Tes	2 2 110
<u> </u>	ysici is cer direct	To Be	examiner? 1 ☐ Yes 2		Hospital:	1 🔲 Inpati	ent 2 🗆	ER/Outpatie	nt 3 □ DO.	A Oth	er: 4 🗆 Nursin	g Home	5 KResi	dence	6 ☐ Other (Spec	cify)
on of	ding Physician: h. After this certific funeral director,	tion: T	27. Manner of Deat	th 5 ☐ Pendir	28a. [Date of Inj Month, Da		28b. Time of Injury		3c. Injur Worl			d. Describe			
Division of Vital Records,	al or Attendi after death. I Director: A d in by the fu	Certification:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	6 Could determ	not be 28e. P	lace of In uilding, e	jury - At ho tc. <i>(Specif</i>)	me, farm, st	reet, factory,	office		28f	Location (City or To			ıral Route Number,
	To the Hospital or Attuvithin 24 hours after de To the Funeral Directo completely filled in by the	Medical C	29a. Certifier (Check only one)	1 Certifyi 2 Medica	ng Physiclan: To I Examiner: On tand	the best the basis of manner s	of examinat	wledge, dea tion and/or i	th occurred a nvestigation,	at the ti	me, date and p opinion, death o	lace, an	d due to the at the time,	cause(s date and	and manner as d place, and due	s stated. to the cause(s)
	To the within Fo the somple	Me	29b. Signature and	title of certific	er		0		29c.	Licens	e number			29d. Da	te signed (Monti	h, Day, Year)
			29b. Signature and	trag &	diferre	- K	aust	UM.	P. [35	527			7/20	6/2011	

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print), VILTORIA STEINE - CARSEN, MD 5411 Old Frederick Rd #18 Baltmore, Md 21329

31. Date filed (Month, Day, Year) 32. Registrar's Signature 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink, Fasure all Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Time of Death Decedent's Name (First, Middle, Last) JUTY 6, 2011 Physician/ Thomas Adkins Garv Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Wicomico 4b. City, Town, or Location of Death Examiner Parsonsburg 31484 Morris Leonard Road If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month Days Social Security Number Sex 1 M 2 D F 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** Months 05/17/1960 Maryland 51 216-70-5185 Director Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State Examiner must be notified at Director 1 🗌 Yes 2 🎽 No Wicomico Parsonsburg Maryland 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number Funeral 21849 USA 7715 Holt Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc þ 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: White Completed 3 Widowed 4 X Divorced other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Construction Carpenter/President Be 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First Middle Last) ဂ Mary Ann Owens Fred Brown Adkins 19a. Informant's Name/Relationship (Type, Print)
Fred B. Adkins/Father 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 31484 Morris Leonard Rd., Parsonsburg, MD 21849 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date wicomico Memorial
Park 1 X Burial 2 Cremation 3 Removal from State ò permit. Page Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) 7/11/2011 Salisbury, MD rvice Licensee Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Wampson CFSP 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cell Corcinona Bose of Du to (or as a consequence of): Physician disease or condition Medical resulting in death) 7col Examiner Sequentially list conditions, if any sequentially list cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical Examiner Due to for as a consequence of attending physician and Due to (or as a consequence of): The law requires that the death certificate be 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year 5 Other (specify) cate has been signed by the a page 2 should be detached to 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform within 24 hours after death.

To the Funeral Director: After this certificate 1 ☐ Yes 2 🕱 No 1 Yes 2 No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) the funeral director, Be examiner? Other: 4 \square Nursing Home 5 \square Residence 6 otin Other (Specify) Home1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d Describe how injury occurred iniury Natural 5 Pending 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practions: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed (Check only one 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier M. D 030690 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar MARTIN

JanesE

31. Date filed (Month, Day, Yea

N.0

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E.

Carroll St., 511.560-4 MD 21801

			For State	State	of Marylan			Health and	Mental Hy			1 24072		
			Registrar 1. Decedent's Name (First, Middle	strar Certificate of Death							2. Date of Death 3. Time of Dea			
	Physicia Medic		Noomi Cortrude Antonelli Iuly							12 2011 4:30 P M				
	Examin	_	E Sin All City Town and a standard a								c. County of Death			
ممريد			8600 Mike Sh	apiro Dri 6.Sex	ve, Apt		Clint If Under 1 Yea		8. Date of Bi			Georges Birthplace (State or Foreign	7	
	Funeral Director		219-10-2399	1 □ M 2 X F	86	Yrs.	Months Days)/1924	4	Country) Maryland		
	d d	L	Usual Residence of Decedent 10a. State 10b. County		10c Cit	y, Town or Loc	cation					10d. Inside City Limits	\dashv	
	arylar Ra-fsh ified a	Director		e Georges		inton						1 ☐ Yes 2XXNo		
	the M or 28	١	10e. Street and Number 10f. Zip Code							10g. Citi	izen of What	t Country?	┫	
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mential Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	8600 Mike Shapiro Dr., Apt. 704 20735								U S A		_	
20		à	11. Marital Status1 ☐ Never Married 2 ☐ Mar3 ☒ Widowed 4 ☐ Divorced	ried Armed For 1 ☐ Yes If Yes, Gir		l II	Vas Decedent of f Yes, specify Cu	ban, Mexican, Puer	pecify Yes or No to Rican, etc.)			American Indian, Vhite, etc. hite		
21213-0030	hours natura iical E	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation						rkina	16b. Kind of Business Industry				
Ž	hin 72 ne. than " e Mec	omo	Elementary/Seconday (0-12) College (1-4 or 5+) life. DO NOT use retired)						irkirig	Cosmetology				
7 0	ed wit Hygie other ent, th	Be C	12 17. Father's Name (First, Middle, I	Last)		<u> </u>	smetolo		me (First, Middle				\dashv	
yland	i be fil fental irked tic ev	ပ							de Poul	e Poulton				
Mary	should and N is ma	9	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route							-				
e, e	and 2 Health em 27 ther to		Bernardina A. I	etcher/Da			2 Letch	er Rd., B	randywi:			v or Town, State	\dashv	
DE L	age 1 ent of nt: If it		1 ☐ Burial 2 🛣 Cremation 4 ☐ Donation 5 ☐ Other (5		n State	emetery, cren	natory or other p	Crem 07/		1		e Hall, MD		
baitimore,	permit. P Departm Importai any injur once.	0	21. Signature of Funeral Service I		A/	22	. Name and Add	ress of FacilityBr	insfield	l-Ech			٦	
מ	8 2 E 6	33	Houston C	6 Mils	M00						<u>lotte</u>	Hall, MD2062	:2	
. P	hysician/	i n	23a. Part 1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition	only one cause on e					c or respiratory a	arrest,		Approximate Interval Between Onset and Death		
	Medical Examiner		resulting in death)		(or as a conseq	uence of):								
	ured nd ansit	Jer	Sequentially list conditions, if any, leading to immediate	b. —	b. Diabetes Due to (or as a consequence of):								-	
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	cate be executed physician and the burial-transit	al E	resulting in death) Last	Due to	(or as a conseq	uence of):								
9	cate b physi s the b	edical		d										
20 X 08 /	e death certiff the attending hed for use a	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	1 🔲 Live	utcome of pregna e Birth 2 Fet gnant at time of known	aldeath 3	Ectopic pregna Other (specify)			-	23d. Date o Month			
s, F.O.	res that th signed by d be detac	d by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. D							id tobacco use contribute to the cause of death?				
or o	w requ s been s shoul	Completed							24a. Wa	s an opsy		e autopsy findings available r to completion of cause of		
ž	The lar ate ha page 2	Som							per 1 🗆 Yes	formed? s 2 No				
ta	ician: Sertific ector,	Be	25. Was case referred to medical examiner?	Hospital:				Place of Death (Ch						
<u> </u>	Io the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Within 24 hours after death. Within 24 hours after this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	e:	1 ☐ Yes 2 ☒ No 27. Manner of Death	28a. Date	e of injury	28b. Time of 28c. Injury at 28d. Describe how injury occurred								
ou		ficat		igation	(Month, Day, Year) injury work? M 1 □ Yes 2 □ No									
Division of Vital Records,		Il Certificate:	3 ☐ Suicide 6 ☐ Could 4 ☐ Hornicide deterr	_inad 28e. Plac	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number City or Town, State)							r Rural Route Number,		
	he Hospit in 24 hour he Funer: pleted fill	Medical	(Check 2 Medical	g Physician: To the Examiner: On the ba g Nurse Practioner	asis of examination	on and/or inves	tigation, in my op	inion, death occurred	d at the time, date	e and place	, and due to	the cause(s) and manner sta	ited.	
	North To t	_	29b. Signature and title of certific				29c. Lice	nse number				fonth, Day, Year)		
			30. Name and address of person	Who completed car		n 23a) /Tuno 1		640		<u> </u>	uly 1	4, 2011		
Pu	19		Khosrow Davac	hi M D	7801 0	ld Bran	nch Aven	ue, Clint	ton, MD	20735	5			
	Sta Registr		31. Date filed (Month, Day Year)	8 2011 32	R gistrar's Signa	ature 1.	bace							

DHMH 17 Rev 7/2009

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rick Francis Co		O Avila State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.
Physici ledical Exami		1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year July 7, 2011 3. Time of Death Month Day 1851 hrs
		4a. Facility Name (if not institution, give street and number) Holy Cross Hospital 4b. City, Town, or Location of Death Silver Spring 4c. County of Death Montgomery
Funeral Director		5. Social Security Number 578-25-9843 1 M 2 F 28 7. Age (In yrs. last birthday) 1 M onths Days Hours Min. 1 M onths Days Hours Min. 1 Months Days Hours Min. 1 Months Days Hours Min. 1 M onths Days Hours Min. 1 Months Days Hours Min. 2 Months Days Hours Min. 3 Months Days Hours Min. 3 Months Days Hours Min. 4 Months Days Hours Min. 5 Months Da
nd show any ace.	5	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No
the Maryland s or 28a-f show tified at once.	Director	10e. Street and Number 502 Chillum Road; Apt. 100 10f. Zip Code 10g. Citizen of What Country? Dominican Republic
Baltimore, MD 21215-0036 gemit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 7: is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	/ Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 15. Yes 2 No 16. Yes, Specify: Black
72 hours af matural	eted by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+) Lementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+) Lementary/Secondary (0-12) College (1-4 or 5+)
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Completed	12th grade Home Improvement Contractor Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
D 2121 should be find Mental is marked	To Be	Salvador Corsino Castillo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20783 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20783 19c. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20783 19c. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20783 19c. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20783
iore, MD ges I and 2 sho tt of Health and t: If item 27 is		20a. Method of Disposition 1 Buriat 2 X Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 3 Value of Disposition (Name of cemetery, crematory or other place)
Baltimore, permit. Pages 1 as Department of He Important: If ite injury or other tr		21 Signature of Funeral Servic Liensee 22 Name and Address of Facility R. N. Horton Company Morticians Inc.;600 Kennedy Street, N.W.; Washington, D.C.20
Physician /Medical xaminer		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or es a consequence of): Sequentially list conditions,
ed nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):
D, be executed sician and urial - transit		d. UNPENDED AMENDED
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 9 Unknown
P.O. Be res that the de signed by the be detached f	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
of Vital Records, as Physician: The law require that this certificate has been s meral director, page 2 should I	Completed	24a. Was an autopsy findings available prior to completion of cause of death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
Vital Rechysician: The this certificate al director, page	To Be	examiner? Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other: Nursing Home 5 Residence 6 Other:
ivision of or Attending Plater death. Director: After I in by the funera		27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of Injury 1800 hrs 28b. Time of Injury 1800 hrs 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred Pedestrian struck by vehicle
Division of To the Hospital or Attending Ph within 24 hours after death. To the Funeral Directors. After completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Shoulder of interstate 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1-495 at 1-95, Silver Spring, MD 29a. Certifier 1 Certifier Physician: To the best of my knowledge death occurred at the time date and place and due to the cause(s) and manner as stated
To the Hospital within 24 hours To the Funeral completely filled	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	Σ	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) July 8, 2011
Ĺ_		30. Name and address of person who completed cause of death (Item 23a) Patricia Aronīca-Pollak MD. Assistant Medical Examiner 900 W. Baltīmore Street, Baltimore, MD 21223
S Reais	tate	

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 24074 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ^D2011 Lillie Myelisa Broadwater July 18, 2:15 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Frostburg Village Nursing Home Allegany Frostburg Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 216-22-5040 Hours Min 1 □ M 2 🛣 F June 26 ′¶°924 Maryland **Director** Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits the Maryland ms 23a or 28a-f sho must be notified at Director MD Allegany Westernport 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 19911 Lohi Drive SW Funeral 21562 United States items death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 12. Was Decedent Ever in U.S. 14. Bace - American Indian. 1 and 2 should be filed within 72 hours after deat of Health and Mental Hygiene. item 27 Is marked other than "natural", or iten other traumatic event, the Medical Examiner. Armed Force Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: If Yes, Give Completed 3 - Widowed 4 - Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Housework Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Harmon Broadwater Harriett Bittinger 19a. Informant's Name/Relationship (Type, Print)
Edison Broadwater/husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19911 Lohi Drive SW, Westernport, Maryland 21562 or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit, Page 1 a
Department of H
Important: If ite
any injury or ot 07/2^{Date}2011 1 Surial 2 ☐ Cremation 3 ☐ Removal from State Laurel Hill Cemetery Barton, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Boal Funeral Home un 111 Church St, Westernport, Maryland 21562 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Ph_sician/ CONGESTIVE Medical resulting in death) Examiner ORONARY cross sticilly list over 9th a se-Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of) as the burial attending physician Physician/Medical certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ ō in the past 12 months? The law requires that the death Month Day Year Pregnant at time of death 1 Yes 2 No 9 Unknown the 9 Unknown P.O. been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? performe certificate 1 Yes 2 No Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 **N**O ျှ 1 Inpatient 2 I ER/Outpatient 3 I DOA Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral director. 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pendina 1 Tes Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 2011 126907 Hullm On Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Harjit Sidhu, 925 Bishop Walsh Road, Cumberland, MD 21502

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, E

Day Year) 2011

Please Type or Print în Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryla Registrar		artment of He tificate of De			iene eg. No. 0	11	24075
			Decedent's Name (First, Middle, Last)				2. Date of Deat			3. Time of Death
	Physicia Medic		Jane LeeWatts Bown	nan			Month July	14. 20	Year 11	9:42 a M
	Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or L	ocation of Death		4c. County		7.72.0
			31 B Mt. View Drive		Boonsbo	ro		Wa	shing	gton
	Funeral		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	s. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	Year)	9. Birthr	olace (State or Foreign
	Director		220-20-3111 09	Yrs.	Wionalio Bayo	Tiodio IVIII.	Dec 16,	1921	Mar	yland
	nd how at	ř	Usual Residence of Decedent 10a. State 10b. County 10c.	City, Town or Loc	cation				- 1	I 0d. Inside City Limits
	arylar a-fs	Director	Maryland Washington	Boonsbor						1 ☐ Yes 2 🛣 No
	or 28 or 08	Ö	10e. Street and Number	DOOLISDOL	10f. Zip Code			l 0g. Citizen of	What Cour	ntry?
	with t	Funeral	31 B Mt. View Drive		21713			U.S.		,
	tems r mu	Fun	11. Marital Status 12. Was Decedent Ever in	U.S. 13. V	Vas Decedent of Hisp Yes, specify Cuban,	panic Origin? (Spe	cify Yes or No-		ce - Americ	can Indian,
ဖွ	ter d , or i	by	1 ☐ Never Married 2 ☐ Married Armed Forces? 1 ☐ Yes 2 🛣 No		Yes, specify Cuban,		Hican, etc.)		ck, White,	
8	within 72 hours after death with the Maryland gjene. er than "natural", or items 23a or 28a-f sho er the Medical Examiner must be notified at the Medical Examiner must be notified at	Completed	3 ☑ Widowed 4 □ Divorced If Yes, Give Year or Dates.		L Yes 2 La No	Specify:		Specify	Whi	te
2	72 ho 1 "nat edica	gle	15. Decedent's Education (Specify only highest grade completed)	(Give I	ent's Usual Occupat aind of work done du	ion ring most of worki	ng	16b. Kind of B	usiness Inc	dustry
21215-0036	ithin ene. thar the M	ပ္ပြ	Elementary/Seconday (0-12) College (1-4 or 5+)		O NOT use retired)	na Asais	tant	Medic	0.1	
9	Hygi Hygi other ent, t	Be (17. Father's Name (First, Middle, Last)	Gerrat	ric Nursi	118 ASSIS 18. Mother's Name				
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ary	nould Ind M s mai		19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street an				State, Zip (Code)
	d 2 sl alth a 127 i ertra		V. June Schmidt	74 Me	adow Lane	Boonsbo	ro, Mary	yland	21713	3
ore,	of Healt of Healt fitem 2			o. Place of Dispo	sition (Name of natory or other place)		Date	20c. Location	- City or To	own, State
Ĕ	Page nent c ant: If ury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	**	reek Cem.	:	8/2011	Hagerst	own,	Maryland
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. A nature of uneral ervice Livensee	22	. Name and Address					
	205 # 9		- Accellance of		06 01d Na					21713
			23a. Part 1. Efiter the disease, or complications that caused the dishock, or heart failure. List only one cause on each line.	eath. Do not ente	r the mode of dying,	such as cardiac o	r respiratory arre	st,		Approximate Interval Between
	nysician/		Immediate Cause (Final disease or condition	ic Ca	neer					Onset and Death
أمريها	Medical Examiner		resulting in death) Due to (or as a cons	equence of):						
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	ed nsit	min	if any, leading to immediate Due to (or as a constance. Enter Underlying Cause (Disease or liniury	equence on.					70	
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09	ate be executed physician and the burial-transit	dical	d							
376	ficate g phys	Ned	_ u							
89	certii andine use a	N/NE	IF FEMALE: 23b. Was decedent pregnant in the part 12 mod ha? 23c. If yes, outcome of pregnant 1 ☐ Live Birth 2 ☐ F		Estapic programay			23d. Da	ate of delive	ery
Division of Vital Records, P.O. Box 687	requires that the death certifica been signed by the attending p should be detached for use as is	by Physician/Me	1 Yes 2 No 4 Pregnant at time		Other (specify)			Mo	onth	Day Year
0	t the c by th	Phy	9 LJ ONKNOWN							
σ.	s tha gned be de	by	Part II. Other significant conditions contributing to death but not	resulting in the u	nderlying cause give	n in Part I.				ne cause of death?
ds	equire sen si ould	Completed					1 L Y			bably 4 Unknown
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Be	cate by						1 🗆 Yes		death?	2 🗆 No
ta	ician sertifi ector	m	25. Was case referred to medical examiner?		26. Plac	e of Death (Check	only one)			
<u>_</u>	Phys this ral dir	<u>1</u>	1 Ves 2 WNo 1 Inpatient 2 27. Manner of Death 28a. Date of injury	ER/Outpatien 28b. Time of	t 3 DOA 28c. Injury a	4 ☐ Nursing Ho	me 5 Reside)
0	ding th. After fune	cate	1 ☑ Natural 5 ☐ Pending (Month, Day, Year)		work?	es 2 🗆 No	zou, Describe no	w injury occur	eu	
Sio	Atten r dear octor:	Certificate:	3 Suicide 6 Could not be 28e. Place of Injury - At	home, farm, stre			28f. Location (St.	reet and Numb	er or Rural	Route Number,
Ξ	al or safte		building, etc. (Spec	cify)			City or Town			
_	To the Hospital or Attending Physician; The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 Certifying Physician: To the best of my known of company of the best of my known of company of the best of a company of the best of the be							
	the H nin 24 the Fi	Me	(Check 2 ☐ Medical Examiner: On the basis of examina only one) 3 ☐ Certifying Nurse Practioner: To the best of							
	To 1		29b. Signature and title of certifler		29c. License r			9d. Date signe		
					D473	188		/	1.18.1	/
Jh	1-5		30. Name and address of person who completed cause of death (It is a share of the s	em 23a) (Type, P	1) 473 Hagerston	wn ma	L 317	42		
	Stat Registra	e	31. Date filed (Month, Day, Year) 32. Rejistrar's Sig	nature	arla					
	– Hegisti a	1	JUL W LOVI DENSUR	10. 14						

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at Baltimore, Maryland 21215-0036 Physicia Medic Examir To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760

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		For State Registrar		State	ot Ma	arylan	-	artment o			-	giene Reg. N	211		24076
Dhominin	,	1. Decedent's Nam									2. Date of Dea	ath		Voor	3. Time of Death
Physicia: Medic		Carroll	-								July 15	\neg	2011	Year	10:40 A ^M
Examin	er	4a. Facility Name (if 16606H St						4b. City, Town	,	on of Death		40		y of Death hingt	on
Funeral		Social Security N	umber 6	i. Sex 1 X M 2 D F	7. Age		ast birthday)	If Under 1 Ye	ear If Und	der 24 Hrs.	8. Date of Birt	th vYear)		g. Birthp	place (State or Foreign
Director		235-32-6. Usual Residence of				3	36 Yrs.				June 3,	192	5	West	[™] Virginia
-f shored at	ctor	10a. State	10b. County	ata a sa			y, Town or Lo							1	0d. Inside City Limits 1 ☐ Yes 2X No
or 28a	Dire	Maryland 10e. Street and Nur		ton		над	ersto	VN 10f. Zip Cod	le			10a. C	itizen of	What Cour	
is 23a	Funeral Director	16606H Sp	piceberr	y Court	:			21740)		1	USA			
or item		11. Marital Status1 ☐ Never Marr	ied 2 🏿 Marrie	12. Was De	ecedent Ev Forces? es 2 1 N	ver in U.S 194		Was Decedent of If Yes, specify Co	of Hispanic Juban, Mexi	Origin? (Spe can, Puerto	ecify Yes or No- Rican, etc.)			ce - Americ ck, White,	
ural", d	Completed by	3 Widowed		If Yes, G Year or	Give	ັ 19₄		1 ☐ Yes 2 🔀	No Spec	ify:			Specify	· Whi	ite
n "nat	nple		15. Decedent' ecify only highest	grade complete			(Give	dent's Usual Oco kind of work dor OO NOT use retire	ne durina n	nost of work	ing	16b. I	Kind of E	Business Inc	dustry
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d z shoul alth and h 1 27 is me er traume		19a. Informant's Na Naomi Bro		(Type, Print) Wife)			1	ng Address (Stre				-			and 21740
age I and ent of He nt: If item y or othe		20a. Method of Disp	position Cremation 3 5	B ☐ Removal fro	om State	0	emetery, cre	osition (Name of matory or other p	olace)	!	Date 0-2011			- City or To	
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2 2 2 2 3		100	790	ll									Liam	sport	,MD 21795
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within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medic	23b. Was decedent in the past 12 i 1 Yes 2 S 9 Unknown	months? ☐ No		ve Birth 2 egnant at	≥ ☐ Feta	death 3	☐ Ectopic pregn☐ Other (specify,						ate of delive onth	ery Day Year
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leath. Ior: Aff the fur	Certificate:	1 Natural 2 Accident 3 Suicide	5 ☐ Pending Investiga 6 ☐ Could no	tion			injury	M 1	/ork? ☐ Yes 2	□ No					
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n 24 hour ne Funera pleted filli	Medical	(Check 2	Certifying P Medical Exa	aminer: On the b	pasis of exa	amination	and/or inves	stigation, in my op	pinion, death	occurred at	the time, date a	nd place	e, and du	ie to the cai	use(s) and manner stated.
Within To the company		29b. Signature and	title of certifier	V. 10 T. 1. 2	7 . ~	Ca	-d -20	29c. Lice	ense numbe	er .		29d. Da	ate signe	d (Month, I	Day, Year)
		30 Name and addre	ess of person wh	no completed ce	ause of de	ath (Item	23a) (Tivne	Print)	+ / 4:	01	747 1/	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	<u>y</u> '	1,000	018
W - I		Synthia 131. Date filed (Month	Kuthner h, Day, Year)	-Sands	Registrar	YOSP	iceof	Washing	gton (County	Hager	sto	wn,	Mary	nue Iand 21742
Registra	r	TI .	JUL 20	2011	Care	R	1 1	arks							

JW-

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death July 07. 2011 Physician/ 1932 Annie Ruth Clark Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🕱 F Months Min Hours Yrs 80 **Director** 249-52-6564 Usual Residence of Decedent 28a-f show 10a. State aţ 10b. County 10c. City, Town or Location 10d. Inside City Limits Director er than "natural", or items 23a or 28a-fs the Medical Examiner must be notified 1 Yes 2 X No Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20904 u.s.A. 13310 Tamarack Road within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Black, White, etc. African-American Armed Forces?

1 Yes 2 No 1 Never Married 2 X Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 Tes 2 No Specify: Completed 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working should be filed within 72 and Mental Hygiene. life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Recorder of Deeds D.C. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Estelle Cunningham permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. Chalmers Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13310 Tamarack Road, Silver Spring, Maryland 20904 Conway Clark - Spouse Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 💹 Burial 2 🗌 Cremation 3 🔲 Removal from State cemetery, crematory or other place) 07/14/2011 | Rockville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Mem. Park 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licensee 111800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph sician/ Pneumatosis Intestinalis disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Metabolic Acidosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events P. Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 X No Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 💢 No Certificate: To 1 🕅 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death pleted filled in by the funeral 28b. Time of 28c. Injury at 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🕱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 068912 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

14 2011

Miriam Lagunas-Fitta, M.D., 3001 Hospital Drive, Cheverly, Maryland 20785

Physicia Medic Examin 1035 Funeral **Director** July 12, 2011 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore, Maryland 21215-0036 CRAWLEY THELMA Physician/ Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial ransit. Division of Vital Records, P.O. Box 68760

	1 – For State Registrar	State of Ma	aryland / De	epartmer Certificat			nd Me		giene Reg. N	011	24078
n/	1. Decedent's Name (First, Middle, Last)	AWLEY					2	2. Date of Dea		20⁴1	3. Time of Death 10:35 A _M
al er	4a. Facility Name (if not institution, give so		enital		Town, or Loc		Death			ounty of Death	1
	5. Social Security Number 6. Sex		e (In yrs. last birthd	ay) If Unde	r 1 Year If	Under 24		B. Date of Birtl	1	9. Birth	nplace (State or Foreign Intry) Virginia
2	Usual Residence of Decedent							верет.	30,13		1 = 8 = 1 = 1
irector	Maryland 10b. County Montgome	ry	10c. City, Town o Rockvil								10d. Inside City Limits 1 X Yes 2 No
eral D	10e. Street and Number 18 Hollyberry C	ourt		10f. Zip	Code 208	52				ed Stat	
Be Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☒ If Yes, Give Year or Dates.			dent of Hispa cify Cuban, N 2 🛛 No S	1exican, P	? (Specif Puerto Ric	fy Yes or No- can, etc.)		. Race - Ameri Black, White pecify: W	
Complet	15. Decedent's Edu (Specify only highest grad Elementary/Seconday (0-12)		i+) (G	ecedent's Usu Give kind of wo e. DO NOT use 1es C1e	rk done dunin e retired)		f working			of Business I	t. Store
To Be	17. Father's Name (First, Middle, Last) Edward W. Willar	d			18	. Mother's Sula		First, Middle, I aven			
	19a. Informant's Name/Relationship (Typ Loretta Reckert	e, Print) (Daughte	er) 19b. N	Mailing Address Holly	S(Street and	Number o	or Rural R	Route Number	City or To	wn, State, Zip D 20852	Code) 2
1	20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		20b. Place of D cemetery, Metropo	crematory or c	ther place)	Jı	11 y Dat 201	[†] 3,		ation - City or T	
	21. Signature of Funeral Service Licensee	1	.116)					1 Funer			MD 20877
	23a. Part 1. Enter the disease, or compli shock, or heart failure. List only one Immediate Cause (Final disease or condition	ications that caused e cause on each line). 	enter the mod			rdiac or r	espiratory arre	est,		Approximate Interval Between Onset and Death
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dical Examiner	If any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	Due to (o) as a	a consequence of). a consequence of):			<i>V</i>		-	-		
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	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 N No 9 □ Unknown	3c. If yes, outcome of 1 ☐ Live Birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death	3					23	d. Date of delive	very Day Year
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Somplet	atrial fibrilla	tion						24a. Was a autop: perfor	sy	prior to co death?	opsy findings available ompletion of cause of
Be (25. Was case referred to medical examiner?				26. Place	of Death (Check o				
ပ	1 ☐ Yes 2 ☐ No		ent 2 ER/Outp		Other:	Nursi	ing Home	e 5 🗆 Reside	ence 6	Other (Specif	5)
ficate:	27. Manner of Death 1 Nunatural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	28a. Date of injur (Month, Day	ry 28b. Tim <i>r, Year)</i> inju		8c. Injury at work? 1 Yes	2 🗆 No	- 1	d. Describe ho	ow injury o	ccurred	
Medical Certificate: To	4 Homicide determined	28e. Place of Inju building, etc	iry - At home, farm c. (Specify)	, street, factor	, office		28	f. Location (Si City or Town		lumber or Rura	al Route Number,
Medic	only one) 3 L Certifying Nurse	er: On the basis of ex	kamination and/or in	nvestigation, in	my opinion, d	eath occur	rred at th	e time, date ar	d place, ar	nd due to the ca	ause(s) and manner stated.
	29b. Signatule and title of certifier Let R. M.	luck	w		License nui	294	/	2	29d. Date s	signed (Month,	Day, Year)
	30. Name and address of person who con	Inch	eath (Item 23a) (Typ	De, Print) M()	ill o	me	Coc	9. Hich	w	Md	2879
e Ir	31. Date filed (Month, Day, Year) JUL 1 4 2011	2. Registra	ir's Signaure	arts.					0		'

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Stat Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 24079 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month JULY Physician/ NANCY LOU CRAMER :07A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year | If Under 24 Hrs Months Days | Hours | Min. 7. Age (In yrs. last birthday) 73 yrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Feb. 17, Year) 1938 218-34-3738 Months Mary Land **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County the Medical Examiner must be notified at 10c City Town or Location 10d. Inside City Limits Director Thurmont Maryland Frederick 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö U.S.A. Funeral 21788 items 23a 125 Cody Drive, Apt. 24 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Black White etc. 0 þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White If Yes, Give Year or Dates 'natural", Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Assistant State Highway Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Clementine Marguerite Foland Charles Franklin Lakel, Sr. permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic to other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
d 125 Cody Drive, Apt. 24, Thurmont, MD 21788 Kenneth L. Cramer, Sr., Husband 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Smithsburg Crematory July 25, 2011 Smithsburg, MD 4 Donation 5 Other (Specify) Signati re of Funer le service Lice e 22Keenevadand Basford PA Funeral Home 106 East Church St., Frederick, MD 21701 M00255 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ 120 disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events and Due to (or as a consequence of): resulting in death) Last burialattending physician for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregriant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of has page 2: autopsy performed? death? certificate 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to dical Be 26. Place of Death (Check only one) Other: 1 Yes 2 No 1 Nopatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office bullding, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical/Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar

DHMH 17 Rev 7/2009

State

29b. Signature

30. Name and address of

31. Date filed (Month, Day, Year

Our

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

INOL

MDD 65378

400 w 7th St

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death OOAM Month Day Year **Physician** CLARK NEISON HARVEY 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town for Location of Death 4c. County of Death Examiner DELCAN WERSUN If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, 9. Birthplace Country) (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Year) 1**X** M 2□ F Months Days Hours Min. 200-20-9763 Pennsylvania Director Usual Residence of Decedent 10d. Inside City Limits 10a, State 10h County 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 No **Funeral Director** MD. Harford Street 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4515 Rosemary's Way 21154 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S.
Armed Forces?
1 Wes 2□ No
If Yes, Give
Year or Dates: Korea 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed witl Department of Health and Mental Hygient Important: If Item 27 Is marked other tha any injury or other traumatic event, Irea once. Auto Repairs Auto Mechanic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Marian Smith Earl David Clark Ruth ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21154 (Wife) P.O. Box Street, Maryland Carole J. Clark 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mem. 2011 Fallston, Maryland Highview Gardens 22. Name and Address of Facility E.G. Kurtz & Son Funeral Home P.A Jarrettsville. 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death death. Do not enter the mode of dying, such as cardiac or respiratory arrest, immediate Cause (Final disease or condition resulting in death) (Zhaine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Be Completed by

Physician /Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and

Baltimore, Maryland 21215-0036

burial-transit the attending pl is certificate has been signed by the director, page 2 should be detached funeral

Medical Certification; To

within 24 hours after death.

To the Funeral Director: A completely filled in by the fi

Division of Vital Records, P.O. Box 68760

Part II. Other significant o	onditions co	ontributin	g to death but not res	ulting in the unde	rlying	cause given in Part I.			se contribute to the cause of death?] No 3 ☐ Probably 4★ Unknown
								24a. Was an autopsy performed? 1 □Yes ♣️No	24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2√No
25. Was case referred to r	nedical					26. Place of De	ath (Check only one)	
examiner? 1 ☐ Yes No		Hospital:	1 ☐ Inpatient 2 ☐	ER/Outpatient	3 🗆 1	OOA Other: 4 Nursing	Home	e 5 ☐ Residence 6	Other (Specify)
	Pending investigation		Date of Injury (Month, Day, Year)	28b. Time of Injury	М	28c. Injury at Work? 1 □ Yes 2 □ No		d. Describe how injury	
	Could not be determined	28e.	Place of Injury - At h building, etc. (Speci	ome, farm, street fy)	, facto	ory, office	28	f. Location (Street and City or Town, State)	d Number or Rural Route Number,
						ed at the time, date and place on, in my opinion, death occ			and manner as stated. place, and due to the cause(s)

29b. Signature and title of certified

29c. License number

Bel Air MO

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

65 W Machail Rd DUBYDIKE

31. Date filed (Month, Day, Year) State JUL 28 2011 Registrar

32. Registrar's Signature Back

and manner stated.

11-05420 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. James Edward Costilow State of Maryland / Department of Health and Mental Hygiene 2011 1- For State Certificate of Death Rea. No Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day July 19, 2011 Costilow Edward James 1956 hrs **Medical Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Rawlings Allegany 23817 Old Stable Road If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5 Social Security Number 6. Sex **Funeral** Foreign Country MD Months Days Hours Director Oct 26, 1992 217-37-2903 1 1M 2 F 18 Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 X No s 23a or 28a-f show e notified at once. MD Rawlings Allegany ore, MD 21215-0036
yes I and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20105 McMullen Highway SW 21557 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. must be or items White, etc. 1 Never Married 2 Married Armed Forces? Yes Specify: White if Yes, Give Year or Dates: 1 Yes 2 X No specify: 3 Widowed Divorced "natural", ፩ 16a. Decedent's Usual Decupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 student school other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) marked Ba Nina Dawson John Costilow 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20105 McMullen Highway SW Rawlings MD 21557 19a. Informant's Name/Relationship (Type, Print) Nina Lancaster mother 20c. Location - City or Town, State Date 20a. Method of Disposition 20b, Place of Disposition (Name of cemetery lore, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Pages 1 7/23/2011 MD Dawson Cemetery Rawlings 4 Donation 5 Other Specify J. Signat re of Funeral Servos Licenses 22. Name and Address of Facility Scarpelli Funeral Home, PA 23a, Par I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, so that scardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** fallure. List only one cause on each line Between Onset and /Medical Death a Methadone Intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial - transit Records, P.O. Box 68760, The law requires that the death certificate be executed Physician/Medical AMENDED 23a, 27, 28a-f, per me, g917 7-29-11 sm X UNPENDED IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Day Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ě 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? performed Yes 2 No 1 🗸 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 26.Place of Death (Check only one) 25. Was case referred to medical B of Vital examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗹 Other: Scene 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Division ___ Natural 1 Yes 2 X No 5 Pending fd 7-19-11 fd 7:00 pm Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 23817 01d Stable Rd. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide 6 X Could not be determined (Specify) Residence of friend Rawlings, Md Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie July 20, 2011 O.C.M.E. Oras124 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Melissa Brassell, MD 32. Registrar's Sissappre 31. Date filed (Month, Day, Year, State Registrar

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1 - State Amend Item 25 per me, g918,08/18/2011dhb
Registrar Registrar Reg. No. 24082 Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ **G**ay JULY 2011 3:30 P M MERLE HALL DENNISON Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WORCESTER BERLIN ATLANTIC GENERAL HOSPITAL If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9, Birthplace (State or Foreign 5. Social Security Number 8 Date of Birth 6 Sex 7. Age (In vrs. last birthday) **Funeral** Months Year) 930 1 □ M 2 🛣 AUG. 18, NORTH CAROLINA Yrs. Director 238-40-2633 80 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 72 hours after death with the Maryland Director 1 X Yes 2 □ No MONTGOMERY ASHTON MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1304 PATUXENT DRIVE 20861 USA "natural", or items 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 X Widowed 4 □ Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical any injury or other traumatic 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) NURSE HEALTH CARE 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ JOHNSON ANNIE WILLIAM ELBERT HALL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1304 PATUXENT DRIVE, ASHTON, MARYLAND 20861 JULI A. FEISSNER/DAUGHTER 20a. Method of Disposition
1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State CREMATORY OF DELMARVA 7/10/11 DELMAR, DELAWARE 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the milde of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Die to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to for as a consequence of, MEDICAL EXAMINER The law requires that the death certificate be executed APPROVED BY that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of) CERTIFICATION Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic preg...☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown Month Day Year Pregnant at time of death ed by the a detached f 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 1 🔲 Yes 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l page 2 s autopsy performed Yes 2 1 Yes 2 No this certificate Division of Vital To the Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical æ examiner? 1 X Yes Hospital: Other: 힏 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Mann of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After of completed filled in by the funer. injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Accident
Suicide Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical 5 aminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3612 9 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 733 Healthway Dr. Berlin MD 21911 Baler MD 31. Date filed (Month, Day, Year) Raistrar's Signature 32. State

Registrar

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Dennison, Meri

ames Michael Da	•	on Si	tate of Maryla		artment of rtificate of		d Mental		Red No 2)	1 2408
Physiciar		Registrar 1. Decedent's Name (First, Midd	dle,Last)					2. Date of De	eath		3. Time of Death
Medical Examin		James Mi	ichael Da	yton				Month July 15,			1530 hrs
	П	4a. Facility Name (if not institution			4	b. City, Town, or	Location of De	eath	4c. County St. Man		1
		Three Notch Road, N			Land birds day N	Hollywood	- 1 12 11 0 4	lies IO Date of I	Si. Iviary		thologo (State or
Funeral Director		5. Social Security Number	6. Sex	7. Age (In yrs. I		If Under 1 Yea Months Days		Min.		Foreig	an
Director		219-72-3656	1 M 2 F	55	Yrs.			01-30	- 1956		untry) Hawaii
any	-	Usual Residence of Decedent 10a, State 10b, County		10c. City	, Town or Locati	on					10d. Inside City Limits
<u> </u>	<u>ا</u> .	Maryland St.	Mary's		Mechan	icsville					1 Yes 2 No
faryland 28a-f show 1 at once.	ᇙ	10e. Street and Number	1101)			10f. Zip Code	1		10g. Citizen of W	hat Cou	ntry?
he Ma	Director	39161 Persimme	on Creek R	load		20659			USA		
11215-0036 Id be filed within 72 hours after death with the Maryland fental Hygiene. arked other than "natural", or items 23a or 28a-f sho vent, the Medical Examiner must be notified at once		11. Marital Status		edent Ever in U				(Specify Yes or N			ican Indian, Black,
death rr iten	Funeral	1 Never Married 2 X M	I 1 X Yes	2 No	II Y	es, specify Cuban	i, Mexican, Pue	ento Rican, etc.)	VVIIII	e, etc.	
after	<u>-</u>		vorced If Yes, Give Yea or Dates:		1	Yes 2 No			Specify:		nite
hours Fran		15. Decedent's Education (Spe Elementary/Secondary (0-12)				's Usual Occupat ost of working life			16b. Kind of B	JSINESS/	industry
36 hin 72 e. than dical		Elementary/Secondary (0-12)	1	1-4-01-3+)	Progr	am Analy	7st		Civil	Ser	rvice
21215-0036 Uld be filed within 7 Mental Hygiene event, the Medica	Completed	17. Father's Name (First, Middle	_	***	11081			ame (First, Middle	, Maiden Surname		
215 215 3e file sked o	8	James Leroy Da	ayton				Delia	Marie P	latt		
21 sould I d Mer is man	₽┞	19a. Informant's Name/Relations			19b. Mailing	Address (Stree	et and Number	or Rural Route N	umber, City or Tov	n, State	, Zip Code) 206.5.9
Baltimore, MD 21215-0036 pernit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		Sheri Dayton	(Wif			- 000		ek Road,	Mechani		
ore, slar of Hes of Hes		20a. Method of Disposition 1 Burial 2 K Crematio	n 3 Removal fr		crematory or oth	tion (Name of cer er place)	metery,	Date	20c. Location	- City Of	Town, State
Page ment of the cott	L	4 Donation 5 Other S	Specify:		insfield	-Echols	07	-18-2011	Charlot	te !	Hall, MD
Baltimore, permit. Pages 1 an Department of He important: If ite		21. Signature of Funeral Service	150/	70.50	22. N	ame and Address	of Facility 22	955 Holl	Lywood Ro	ad	20650
	-	Edward N. Brins 23a. Part I. Enter the disease, o	r complications that c	MUUU52 aused the death	. Do not enter th	.nsileld e mode of dving.	Funera such as cardia	L Home,	rrest, shock, or he	nar	dtown, MD Approximate Interval
Physician Medical		failure. List only one cause	e on each line.								Between Onset and Death
≟xaminer	1	Immediate Cause (Final disease or condition resulting in death)		consequence of	of):						
		Sequentially list conditions,	b								
	<u> </u>	if any, leading to immediate cause. Enter Underlying Cause		consequence o	of):						
	Examine	(Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of	of):						
be executed ician and urial - transit			d								
be ex sician urial	gica	UNPENDED	AMENDED								
Box 68760 e death certificate to the attending physical for use as the bu	Š	IF FEMALE: 23b. Was decedent pregnant in t		outcome of preg		al death 3	Ectopic pre	gnancy	23d. Date of Month		y Day Year
x 68 h certi tendin use a		past 12 months?	4 Pregr	nant at time of de		ner (Specify)					
BO e deat	Physician/Me		1known 9 Unkno					Tan au		7	
hat th detach	g P	Part II. Other significant condi	tions contributing to	o death but not r	esulting in the u	nderlying cause g	given in Part I.				the cause of death?
S, F puires an sign	9										topsy findings available
ord aw rec as bee	Completed							aut	opsy		completion of cause of
Rec The licate h	ĕ							1 ✔ Yes		√ Ye	es 2 No
cian: certifi ector,	Be	25. Was case referred to medical examiner?	Managhab		1		of Death (Che		10	4 0#	0
Physical direction	인	1 ✓ Yes 2 No 27. Manner of Death	28a. Date	Inpatient 2	ER/Outpatient 28b. Time of Ir		ry at Work?		Residence 6 e how injury occur		r, Scene
n O n oding	팅	1 Netural	Jul 15, 2	Day, Year) 2011	1530 hrs	· I —	Yes 2 ✓ No	Passenge			was involved in a
SiO Aften r deat ector by the	[평	2 Accident Inve	estigation 28e Plac	e of Injury - At h	ome, farm, stree	t, factory, office b		collision 28f. Location	(Street and Numb	er or Ru	ıral Route Number, City
Division of Vital Records, P.O. tal or Attending Physician: The law requires that it is after death. In Director: After this certificate has been signed by the funeral director, page 2 should be detacted.	Certification:		lid not be	Woods	,,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	<i>J.</i>	or Town	State)		Road, Hollywood, M
			Physiclan: To the bes		lge, death occur	ed at the time, da	ate and place,	and due to the ca	use(s) and manne	r as stat	ed.
o the lithin 2 or the long the	Medical	one) 2 Medical Exa	aminer: On the basis and manner s	of examination a	and/or investigat	on, in my opinion	n, death occurre	ed at the time, dat	te and place, and	due to th	e cause(s)
E ME S	\$	29b Signature and title of certifi				29c. Licens	e number		29d. Date sign	ied (Mo	nth, Day, Year)
	- [Pot arra	mi -t	'alli	-	O.C.I	M.E.		July 16, 20)11	
)	ŀ	30. Name and address of person				000144 5 111	O:	D-W	4D 04000		
one		Patricia Aronica-Polla		ant Medical		SUU VV. Baltır	nore Street	, Baltimore, N	VIU 21223		···
Sta Registr	te ar	31. Date filed (Month Pay, Year	2011	egistrar's Signat	J. por	w					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Robert **Alexander** Dailey Dailey 7:20 a M July 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town. or Location of Death 4c. County of Death St. Mary's Leonardtown 39950 Sassafrass Lane 9. Birthplace (State or Foreign Country) Maryland Social Security Numbe Year If Under 24 Hrs 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** 1 X M 2 □ F Months Hours 08/09/1934 Director 217-32-0026 76 Usual Residence of Decedent 28a-f show 10a State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Funeral Director ems 23a or 28a-f sh r must be notified a Maryland St. Mary's Leonardtown 1 Yes 2X No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 20650 39950 Sassafras Lane USA items "natural", or item edical Examiner n Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Bace - American Indian. Armed Forces?

1 Yes 2 No If Yes, Give Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed **Black** Year or Dates other than "natu ent, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Carpenter Builder Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 27 is marked of traumatic even and Mental ပ Walter Dailey Ida Juanita Briscoe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Health a Annie T. Berry/Step-Daughter 39950 Sassafras Lane, Leonardtown, MD 20650 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State St. Mark's UAME 4 Donation 5 Other (Specify) 07/23/2011 Valley Lee, MD Name and Address of Facility
Mattingley-Gardiner Funeral Home,
P.O. Box 270, Leonardtown, MD 20650 21. Signature of Funeral Service Lice Jarole 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician, arlest disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) thma and burial-trar Due to (or as a consequence of) resulting in death) Last ed by the attending physician detached for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be e 24 hours after death. 54 hours after death. • Funeral Director: After this certificate has been signed by the attending physicia Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death Other (specify) 4 Pregnant Yes 2 No 9 Unknown Division of Vital Records, P.O. signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Completed 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed page 2 1 Yes 2 No 25. Was case referred to medica examiner? funeral director, Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Other: ၉ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No Accident Investigation completed filled in by the 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 only one) 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Sign ture and title of certifie 29c. License number 29d. Date signed (Month, Day, Year, MD D 63314 0//

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State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signatu

and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

Jyoti D. Shah, M.D. 24035 Three Notch Rd., Hollywood, MD 20636

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month SAYAGE BECCA 0825 Medical 2011 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Wicomico ry Rehabilitation & Nursing City Number 6. Sex 7. Age (In vrs. last birth sbi If Under : 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min Director show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director SALISBURU 1 Yes 2 □ No Wicomico 10e. Street and Number 10f. Zo Code 10g. Citizen of What Country? Completed by Funeral 21801 ()SA NANTICOKE Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married 1 Yes 2 0 If Yes, Give Year or Dates. 3 Widowed 4 Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Cellege (1-4 or 5+) life. DO NOT use retired) Elementary/Seconday (0-12) Dolbers Cleanin Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည LMON elationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26110 WANTERER RD SALISBURY Son Itimore, 20b. Place of Disposition (Name of Method of Disposition ■ Burial 2 ☐ Cremation 3 ☐ Removal from State Remember men 90 4 Donation 5 Other (Specify) tebran, mo 21. Signature of Funeral Service Licer 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on social line. Interval Between Onset and Beath Immediate Cause (Final Physician/ disease or condition 200000 Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and -tran: Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Day Year 2 No 1 Yes 2 L Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Ures 2 □ No 3 □ Probably 4 □ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy 2 No 1 Yes 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 1 MO Other: မ 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred s after dea... ral Director: Aftr 1 Natural 5 Pending injury Accident 1 Yes 2 No Investigation M 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by th Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medica 29a. Certifier 1 🖵 crtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year, JTE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 200 Ci Vic. 31. Date filed (Month, Day,

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Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month JUL Physician/ BERGER HE 500 AM 2011 Medical 4a. Facility Name (if not institution, give street and number)
Kers of the Nors of the Rehab C **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 16tssing TON MONIGOMER If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex Age (In yrs, last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 W Hours Min. -50-984 Director Carolina South Usual Residence of Deceder or 28a-f show ntal Hygiene. ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at. 10b. County 10c, City, Town or Location Director 10d. Inside City Limits 1 🛚 Yes 2 🗆 No 01ney Maryland | Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 18301 Georgia Avenue #211 20832 United States death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ş altimore, Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: African American 3 Widowed 4 Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with h and Mental Hygien 7 is marked other th Dietician Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit, Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev ည Sherfield McWhorter Inez Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clarice Young - Daughter 2714 Rittenhouse Avenue Baltimore, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Maryland 20c. Location - City or Town, State Date 1 🛮 Burial 2 🗆 Cremation 3 🗔 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cheltenham, Maryland Veterans Cemetery 21. Signature of Funeral Service Licens 22. Name and Address of Facility Stewart Funeral Home, Inc. Washington, DC 20019 4001 Benning Road NE Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ erebrovasca disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of spital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial Physician/Medical Box 68760 attending pl IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ___ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year ed by the a detached t 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? Completed by EMPOSIEM 1 Yes 2 No 3 Probably 4 Unknown Melli DiAbetes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? Yes 2 WNo 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2 No Other: 은 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 \square Pending work? within 24 hours after death. To the Funeral Director: Al Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D0053337 30. Name and address of pagon who completed cause of death (Item 23a) (Type, Print) 2835 Smith Baltimore Avenue Ste 203 Seay MD 31. Date filed (Month, Day State

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			1 - State of Mary State of Mary		artment of F rtificate of L			110 San	24087	
	Physicia Media		1. Decedent's Name (First, Middle, Last) Irwin Fried	nan		_	2. Date of Death Month July 0		3. Time of Death 8:25р м	
مدر	Examir		4a. Facility Name (if not institution, give street and number) 15100 Interlachen Drive, #1		Si	Location of Death		4c. County of Dear	-	
Ì	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In Usual Residence of Decedent	yrs. last birthday) 89 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Y May 12,	9. Bir 1922 Co	thplace (State or Foreign untry) New York	
	Maryland 28a-f show atified at	Director		c. City, Town or Lo		ver Spriv	ıg		10d. Inside City Limits 1 ☐ Yes 2 🕱 No	
	is 23a or surst be no	Funeral Di	10e. Street and Number 15100 Interlachen Drive, #1	014	10f. Zip Code	20906	10	10g. Citizen of What Country? U.S.A.		
9800	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates.		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 🌠 No	n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify:		
Maryland 21215-0036	within 72 ho /giene. ner than "nat ner the Medica t, the Medica	e Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)	(Give	dent's Usual Occup: kind of work done o O NOT use retired) Farm	luring most of wor	king 1	6b. Kind of Business Poultry	_{Industry} Husbandry	
yland	uld be filed Mental Hy narked ott natic eveni	To Be	17. Father's Name (First, Middle, Last) Bernhard Fried	nan		18. Mother's Nan	ne (First, Middle, Ma Ida P	,		
e, Mar	und 2 shou lealth and im 27 is m her traum		19a. Informant's Name/Relationship (Type, Print) Sema Friedman - Spouse	15100	Interlac			ity or Town, State, Zij ver Sprin	o Code) g, MD 20906	
Baltimore,	Page 1 a tment of h tant: If ite jury or ot		1 🗓 Burial 2 🗆 Cremation 3 🗆 Removal from State	arden of	natory or other plac Remembro	ince 07/1	3/2011 0	oc. Location - City or Larks burg	, Maryland	
Bai	permit Depart Impor any in			162/ 11	800 New 1	<i>lampshire</i>	Ave., Sa	lver Spri	l Home, Inc. ng, MD 20904	
~ [Physician/ Medical		23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Bronch Due to (or as a condition of the condition		er the mode of dying	g, such as cardiac	or respiratory arrest		Approximate Interval Between Onset and Death Y LAVS	
337	Examiner	ner	Sequentially list conditions, if any, leading to immediate Due to (or as a cor							
09	ate be executed obysician and the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last C	sequence of):						
P.O. Box 6876	Iothe Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours afor Attending Physician: To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transity.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 9 Unknown	Fetal death 3	Ectopic pregnanc	у		23d. Date of de Month	ivery Day Year	
s, P.O	ires that the signed by detaction	d by Pł	Part II. Other significant conditions contributing to death but no Parkinson's with Dysphagic		nderlying cause giv	en in Part I.			the cause of death?	
Division of Vital Records,	The law requ	Completed by	Coronary Artery Disease				24a. Was an autopsy performe	24b. Were au prior to death?	topsy findings available completion of cause of	
<u> </u>	ctor, p	Be	25. Was case referred to medical examiner?		26. Pla	ice of Death (Chec		110		
5	hysic his o	은		2 ER/Outpatien	nt 3 DOA Othe	r: 4 Nursing H	ome 5 🕅 Residenc	e 6 Other (Spec	ify)	
ion oi	ttending P death. tot: After t the funera	Certificate:	27. Manner of Death 1				28d. Describe how			
	pital or A burs after eral Direc filled in by		4 Homicide determined 28e. Place of Injury - building, etc. (Sp	ecify)			City or Town, S		ŕ	
:	o the Hos ithin 24 h the Fun ompleted	Medical	29a. Certifier defended in 1	nation and/or invest	igation, in my opinio	n, death occurred a time, date and pla	t the time, date and poet, and due to the ca	place, and due to the use(s) and manner as	cause(s) and manner stated. stated.	
	3		> Bun M			D23958	290	July 11		
			30. Name and address of person who completed cause of death Burt Feldman, M.D., 3305 N.	Leisure	World Bl	ud., Sil	ver Sprin	g, Maryla	nd 20906	
	Stat Registra	_	31. Date filed (Month, Day, Year) 82. Registrar's S	greature for						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 24088 State of Maryland / Department of Health and Mental Hygien ? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Leonelda Irene Farris JUIV 16 2011 12:55 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Moran Manor Nursing Center Westernport Allegany . Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8 Date of Birth **Funeral** 9. Birthplace (State or Foreign 235-16-0780 1 M 2 St F Months Days Hours Feb. 17 91 West Virginia Director 7920 Usual Residence of Decedent "natural", or items 23a or 28a-f show idical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director DE Sussex Seaford 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23099 Ross 19973 Station Road United States 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 Married ģ Yes 2 K No white If Yes, Give Year or Dates 1 Yes 2X No Specify: Completed 3 Widowed 4 X Divorced Specify: is marked other than "natur aumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) unknown Homemaker Housework Be permit. Page 1 and 2 should be filed in Department of Health and Mental Hyy Important: If item 27 is marked oth any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Albert. Fazenbaker SR Irene Rebecca Stuby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Richard Farris JR/son 23099 Ross Station Road, Seaford, DE 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State 07/18/2011 Cumberland Maryland Cumberland Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Boal Funeral Home 111 Church St, Westernport, Maryland 21562 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease of initiary that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ Pregnant at time of death Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Reap failure, HTN eted 1 1 Yes 2 No 3 Probably 4 Unknown

To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans Division of Vital Records, P.O. Box 68760 signed by the filled in by the within 24 hours af

To the Funeral Di

completed filled in

within 72 hours after death with the Maryland

Mental Hygiene.

Baltimore, Maryland 21215-0036

			24a. Was an autopsy autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No
ย	25. Was case referred to medical examiner?	26. Place of Death (Check on	nly one)
2	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home	5 Residence 6 Other (Specify)
ilcare.	27. Manner of Death Natural 5 Pending Accident Investigation Suicide 6 Could not by	28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at work? M 1 Yes 2 No	I. Describe how injury occurred
al cell	4 Homicide determined		. Location (Street and Number or Rural Route Number, City or Town, State)
Š	29a. Certifier 1 Certifying Phys	sician: To the best of my knowledge, death occured at the time, date and place, and di	ue to the cause(s) and manner as stated.

only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number MD Slave

26726

29d. Date signed (Month, Day, Year)

118

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Harshad Bokil, 566 S. Mineral St, Keyser, WV

31. Date filed (Month, Day, Year State JUL 18 2011 Registrar

29b. Signature and title of certifier

Harmoo



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

	Stat	e ir	31. Date filed (Month, Day, Year)	9 2011 32. Re	strar's Signat	ure /	Sare		VE, DEL	IESDA, M	ARILA	ND 20092
N	10		30. Name and address of person Rachel Sci		of death (Item	23a) (Type, Pr	•	דמת קקין	VE BETH	IECDA M	ADVT A	ND 20892
	F S F Ö			cheraga	MD			06924	9		17,	
	o the Ho	Medical	(Check 2 <u>☐ Medical E</u>	Examiner: On the basis of Nurse Practioner: To	of examination	and/or investi-	gation, in my opinie	on, death occur e time, date an	red at the time, da	te and place, and	due to the manner as	cause(s) and manner stated. stated.
DIVI	spital or /		4 Homicide determ	building,	etc. (Specify)	edge, death o	ocured at the time	, date and place	City or	Town, State)	anner as str	ral Route Number,
Division of Vital Records, P.O.	Attending r death. ctor: After y the fun	Certificate:	1 ☑ Natural 5 ☐ Pendir 2 ☐ Accident Investi 3 ☐ Suicide 6 ☐ Could	gation not be	Day, Year) Injury - At ho	injury me. farm. stre	worl	ć? Yes 2 ☐ No	<u> </u>			iral Route Number
of V	ig Phys ter this c	te: To	27. Manner of Death	1 Malng 28a. Date of	injury	ER/Outpatient 28b. Time of	28c, Injur	4 L Nursi yat	ng Home 5 R	esidence 6 🗆 o		cify)
ita	sician certifi rector,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:			Oth		Check only one)			
Rec	sician: The law I certificate has b irector, page 2 s								aı	utopsy erformed?/ es 2 No	prior to death?	completion of cause of
ords	v requires been substantial	Completed			<u> </u>				1		b. Were au	robably 4 Unknown
P.0	es that ti igned by be deta	þ	Part II. Other significant condition	ons contributing to deal	th but not res	ulting in the ur	nderlying cause gi	ven in Part I.				the cause of death?
. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 Live Bir	th 2 ☐ Feta ntattime of d	ldeath 3 🗌	Ectopic pregnant Other (specify)	cy			Date of de Month	livery Day Year
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	Physician/ Medical	å N	Immediate Cause (Final disease or condition resulting in death)	a. Due to (or	SiS as a consequ	uence of):					-	Onset and Death 24 Nours
	L - = 0 0		23a. Part 1. Enter the disease, or shock, or heart failure. List	r complications that cau	used the deat						e, PA	Approximate Interval Between
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 Burial 2 Cremation 4 Donation 5 Other (a				darden		7/22/201 Ewing_Br		isle, I Tun en a	l Home Inc. 17013
lore,	ge 1 and nt of Heal : If item; or other		20a. Method of Disposition		20h F	Place of Dispos	aition (Name of		Date	20c. Locati	ion - City or	Town, State
Mary	2 should Ith and M 27 is mai traumat		19a. Informant's Name/Relations	hip (Type, Print) Daughte:	r	19b. Mailin	g Address (Street Harri:	and Number of sburg I	or Rural Route Nur Pike Ca	nber, City or Tow rlisle,	n State Zi	(c.Code)
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5-003	hours aff natural", ical Exal	leted !	3 Widowed 4 N Divorced	d If Yes, Give Year or Date			Yes 2 No			-	of Business	
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21215-0036 ould be filed within 7	Mental Hygiene. marked other than "natural", or items 23a or 28a-f she c event, the Medical Examiner must be notified at once	ВеС	PIETRO OTTAVIO F	Τ.Δ ΤΜ			10.				LE HAL		
21; ould b	d Men s mar	ToE	19a. Informant's Name/Relationship (Type, Prin					nd Numbe	r or Rur	al Route Num	ber, City or Tow	n, State	
Baltimore, MD permit. Pages 1 and 2 sho	Department of Health and N Important: If item 27 is n injury or other traumatic			OUSE							URY, M		
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Records, P.O. Box	been signed by hould be detach	ģ				101 J.C							ably 4 Unknown
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19	- Bu		30. Name and address of person who completed	d cause of death (Item	23a)			_					
				dical Examiner		imore St	reet, E	Baltimo	re, MD	21223			
	St Regist	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	ile								

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 11-04965 State of Maryland / Department of Health and Mental Hygiene Vernon Matthew Gamble 2011 1- For State Certificate of Death Reg. No Registrar 2. Date of Death Physician/ 3. Time of Death 1. Decedent's Name (First, Middle,Last) Month D July 3, 2011 0010 hrs **Medical Examiner** GAMBLE VERNON MATTHEW 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Prince George's 8500 Block of Central Avenue Landovei If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Foreign Months Days Hours Director Country)WASH. D.(MARCH 5,1988 1X M 2 F 23 578-15-5701 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 X Yes 2 No 28a-f shov or items 23a or 28a-f shormust be notified at ooce. NONE WASHINGTON D.C. within 72 hours after death with the Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4015 4th ST. S.E. U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. Armed Forces 1 Never Married 2 X Married 2 X No Yes 4 Divorced If Yes, Give Year BLACK Yes 2 X No specify: Specify. \$ 16a, Decedent's Usual Occupation (Give kind of work done 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) altimore, MD 21215-0036 mit. Pages I and 2 should be filed within 72 h partment of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 NONE NONE 17 Father's Name (First Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be VERNON DAVIS VERSIE GAMBLE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1210 CAPITOL HGTS. BLVD., CAPITOL HGTS., MD.20743 ANGELIQUE GAMBLE/WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Baltimore. crematory or other place) 1 Burial 2 X Cremation 3 Removal from State JULY 18,2011 CHAMBERS CREMATORY RIVERDALE, MD. Donation 5 Other Specify 21. Signature of Funeral Service License 22.Name and Address of Facility CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. M00091 5801 CLEVELAND AVE., RIVERDALE, MD. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure, List only one cause on each line Medical Death a. Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Examiner if any, leading to immediate Due to (or as a consequence of): cause Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical AMENDED UNPENDED signed by the attending physician be detached for use as the burial certificate be of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ğ 1 Yes 2 No 3 Probably 4 Unknown Completed certificate has been rector, page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? Yes 2 No 1 Yes 2 No To the Hospital or Atteodiog Physician: within 24 hours after death.

To the Fuoeral Director: After this certifi completely filled in by the funeral director, 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 Inpatient Other 1 Nursing Home 5 Residence 6 🗸 Other: Scene 2 ER/Outpatient 3 DOA 1 Yes 2 No ၉ 28a. Date of Injury Jul 2, 2011 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: Subject pedestrian in roadway struck by vehicle 2353 hrs 1 Natural Division 1 Yes 2 ✔ No 5 Pending and run over 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) 8500 Block of Central Avenue, Landover, MD determined (Specify) Major Road / Highway 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c, License number 29d. Date signed (Month, Day, Year) 29b July 3, 2011 O.C.M.E. Vel 30. Name and address of person who completed cause of death (Item 23a) 900 W. Baltimore Street, Baltimore, MD 21223 Victor Weedn MD JD Assistant Medical Examiner . Registrar's Signa ure State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 24092 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2:30 a M Gregory July Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Bay Ridge Health Annapolis Anne Arundel Social Security Number 7. Age (In vrs. last birthday) **Funeral** If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) (Month, Day, Days 1 M 2 A F Months Hours Director 1913 Washington D.C 578-62-1593 98 May Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director DC Washington 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4015 Massachusetts Ave. S.E. 20019 United States 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Black, White, etc. à 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give 1 Yes 2 No Specify. "natural" 3 X Widowed 4 Divorced Specify: Negro/Caucasian Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) nould be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Chair Library Board 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be file f Health and Mental H item 27 is marked o 2 Richard Drew Nora Burrell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 506 Tulip Road Annapolis, Md 21403 Frederick Drew Gregory/son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Important: If it Page 1 injury or c 1 ▲Burial 2 ☐ Cremation 3 ☐ Removal from State Lincoln Memorial 7/18/2011 4 Donation 5 Other (Specify) Suitland, Md 21. Signature of Funeral Service Licens 22. Name and Address of Facility McGuire Funeral Service Inc. any Joanna E. Elsberre 7400 Georgia Ave. NW Washington, DC 20012 Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Advanced dementia Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 X No Por Day Month Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
 1 □ Yes 2 □ No Hypothyroidism 24a. Was an autopsy ormed? 2. **X** No Hospital or Attending Physician: Be 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? Other: 4 🗷 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) Hospital: 2 X No ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 1 X Natural 5 Pending injury work?
1 \(\subseteq \text{Yes} \) 2 🔲 No ☐ Accident ☐ Suicide Investigation after death Director: / 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 24 hours a Medical To the Hosp within 24 hor To the Fune completed fi 29a. Certifier 14 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated, Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D0063681 10 13 11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Ajit Kurup MD

31. Date filed (Month, Day, Year) **JUL 14 2011**

1835

Baltimore, Maryland 21215-0036

68760

Box (

Records,

Division of Vital

University Blvd. East Suite 208 Hyattsville, Md 20783

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 Madeline Louise Greely July 1:20 Рм Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Gilchrist Hospice Care Towson If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 5. Social Security Numbe 217–38–3787 Months Aug. 29, Year) 1943 Days 1 M 2 X F Hours Maryland 67 Director Usual Residence of Decedent at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director r 28a-f sh notified a Westminster Carroll Maryland 1 Yes 2X No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funera USA 21157 446 Bennett Cerf Dr. 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) tal Hygiene. ed other than "natural", or iten event, the Medical Examiner I 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 XNo Specify. 3 Widowed 4 Divorced Specify: White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Registered Nurse Elementary/Seconday (0-12) College (1-4 or 5+) Johns Hopkins Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental I 27 is marked or traumatic eve Josephine Bertha Ruscewicz William Christopher Ryan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 446 Bennett Cerf Dr., Westminster, MD 21157 Health tem 27 Gary Kenneth Greely/Husband item 2 Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite 1 Burial 2 **Cremation 3 **Removal from State ö Carroll Cremation Inc 07/09/2011 Hampstead, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses Pritts Funerally Home and Chapel, P.A. 412 Washington Rd., Westminster, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Nonsmall coll disease or condition months Medical resulting in death) Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last use as the burialphysician Physician/Medical Box 68760 IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year Pregnant at time of death page 2 should be detached g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, I **Division of Vital** Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) NOSPICE 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending work? Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital within 24 hours a To the Funeral D Medical Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my printed death. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signatur 29d, Date signed (Month, Dav. Year) WIL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 TOUSON MD 21204 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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	•	For State Registrar		State c	ot iviary	yland		tificate		lealth and N Death		giene Reg. No	20		24094
Physicia	n/	1. Decedent's Name			. 4-		_		_		2. Date of Dea		3, 2	∩ _X eat	3. Time of Death 11:45P M
Medic Examin	ai	Kathlee 4a. Facility Name (if		ise Gris				4b. City, To	wn, or	Location of Death	July			y of Death	11.4JI M
à				as Drive,				Wal	ldo:	rf If Under 24 Hrs.	O Date of Did		Cha	rles	(0)
Funeral Director	- 1	5. Social Security No. 579–38–89	07	6. Sex 1 □ M 2 XF	7. Age (In		79 Yrs.		Days	Hours Min. A	8. Date of Birt ugust. Date ugust.	, [/] 1 ^a 9	31		ace (State or Foreign Angton DC
land show dat	tor	Usual Residence of 10a. State	10b. County		10	c. City,	Town or Loc	ation						10	0d. Inside City Limits
or 28a-i	Direc	MD 10e. Street and Num		harles		_	Wald	lorf 10f. Zip C	ode			10a C	itizen of	What Coun	1 Yes 2 X No
s 23a c	Funeral Director			as Drive,	Apt.	313	3			20602			US		
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ρ	11. Marital Status1 ☐ Never Marri3 ☐ Widowed		If Voc Civ	rces? 2 X No	in U.S.	If	Vas Deceden Yes, specify ☐ Yes 2	/ Cubai	spanic Origin? (Spe n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)			ce - America ck, White, e	
72 hour n "natu ledical	Completed		cify only high	nt's Education est grade completed)			(Give k	ent's Usual (ind of work () NOT use re	done d	ation Juring most of work	ing	16b. k	Kind of E	Business Ind	lustry
within giene. ner thau	e Con	Elementary/Seco	onday (0-12)	College (1	-4 or 5+)		me. Do	Home		er				Но	me
uld be filed Mental Hy narked oth	To Be	17. Father's Name (I	A. Qu	ade						18. Mother's Nam	, .		Surnam	ne)	
12 shouth and 12 strain reference		19a. Informant's Na Don Gris						_		and Number or Rura as Drive,					
Page 1 and nent of Hes int: If item iny or othe		20a. Method of Disp	oosition Cremation	3 Removal from	State	cer	ce of Dispo netery, crem	sition (Name natory or othe	of er plac		Date	20c. L	ocation	- City or To	wn, State
permit. I Departin Importa any inju		21. Signature of Fur	neral Service I	Licensee L. L.	м009	45	22 A	Name and AREHAR	Addres T-E	s of Facility CHOLS FUN	NERAL HO	OME,	P.A.		
		23a. Part 1. Enter t shock, or hear	he disease, or rt failure. List	r complications that conly one cause on ea	caused the	e death.	Do not ente	r the mode o	of dying	ary's Ave g, such as cardiac o	or respiratory an	Lata rest,	, MD		Approximate Interval Between
Physician/ Medical		Immediate Cause (disease or condition resulting in death)		a. Me	+a	S -	+ O-	tic	/	Melo	200	m	<u>a</u>		Onset and Death
Examiner	Je.	Sequentially list co	nditions,	b. —	,										
executed an and rial-transit	Examiner	if any, leading to im cause. Enter Under Cause (Disease or that initiated events	rlying iinjury	C	or as a co	nseque	nce ot):								
E : 6	= 1	resulting in death) I			or as a co	nseque	nce of):								
tificate I ng phys as the	Medic	IF FEMALE:		d											
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but the but the funeral director.	Physician/Medica	23b. Was decedent in the past 12 1 Yes 2 9 Unknown	months?		Birth 2 [nant at tim	Fetal	death 3	Ectopic pre Other (spec		у				ate of delive onth	ery Day Year
v requires that the described size of the sensioned by the should be detached	by	Part II. Other signif	ficant conditi	ons contributing to d	eath but n	not resul	ting in the u	nderlying ca	use giv	en in Part I.					e cause of death?
sician: The law req s certificate has bee lirector, page 2 sho	Completed										24a. Was autoj perfo			prior to cor death?	osy findings available inpletion of cause of 2 No
sician: certificilirector,	To Be	25. Was case referre examiner? 1 Yes 2	ed to medical No	Hospital:	Innationt	2 🗆 🗉	D/Outnation	t 3 🗆 DOA	Othe	ace of Death (Checker:	11	donas	6 \(\tau_{\text{ot}}\)	nor (Specific	
To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate he completed filled in by the funeral director, page		27. Manner of Death 1 Natural 2 Accident		28a. Date (Mon		2	8b. Time of injury		. Injury work	/ at	28d. Describe h				
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completed filled in by the fu	Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 Could detern	not be 28e. Place	of Injury - ng, etc. (S		ie, farm, stre	et, factory, c	office		28f. Location (\$ City or Tox			ber or Rural	Route Number,
he Hospit in 24 hour he Funera pleted filk	Medical	(Check 2	Medical I	g Physician: To the be Examiner: On the bas g Nurse Practioner:	sis of exam	nination a	and/or invest	igation, in my	opinio	n, death occurred a	t the time, date a	and plac	e, and du	ue to the cau	use(s) and manner stated.
To t with To t		29b. Signature and	title of certifie	H to	de (CF	CNT	29c. L	icense	11453		29d. Da	ate signe	ed (Month, L 4 T	Day, Year)
Bie		Dixie	100	who completed caus	-	P	OB	rint)	15	103 L	aPla	la	M	60	0646
Stat Registra		31. Date filed (Mont	n, Day, Year)	1 5 2011 32. F	egstrar's	Signatur	A. 1	parke	1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 24095 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July Marie Mildred Gassman 2011 5:50 PMM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Wicomico Nursing Home Salisbury Wicomico 5. Social Security Number If Under 1 Year If Under 24 Hrs. . Age (In yrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 1 - M 2 X F Months Days Hours Min. 0373171915 Director 220-40-8793 96 Maryland Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland Director 1 X Yes 2 □ No Salisbury Maryland Wicomico 10e. Street and Number 10f. Zip Code ral", or items 23a or Examiner must be n 10g. Citizen of What Country? Completed by Funeral and 2 should be filed within 72 hours after death with Health and Mental Hygiene. 1109 S. Schumaker Drive 21804 USA Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🛣 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married timore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 X Widowed 4 Divorced White Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Housewife Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Theodore Franklin Brown Florence Gertrude Myers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marilyn Booth/daughter 8402 Hilda Dr., Salisbury, MD 21804 Department of Hea Important: If item 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State St.comarycostownitedochurch 4 ☐ Donation 5 ☐ Other (Specify) Christ Cemetery Silver Run, MD 7/12/2011 urvice Licensee Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting In death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Vear Pregnant at time of death 9 Unknown signed by the Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>გ</u> 1 Yes 2 No 3 Probably 4 Unknown Completed plnous Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy performed?

Yes 2 No death? 2 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, To the Hospital or Attending Physician: 25. Was case referred to dical Be 26. Place of Death heck only one) examiner? 2 DNO 1 Tyes Other မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manne f Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Watural . 5 \square Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

(OTP

Registrar

rson who completed cause of death (Item 23a) (Type, Print) Mahesha Thimmarayappa M.D.

910 Easternshore Dr Salisbury MD 21804

29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day, Year)

32. Re

29b. Signatu

11-05423 Clarence Ganzman

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2011 24096

Physician Medical Examiner 1. Decedent's Name (First, Middle, Last) Clarence Leroy Ganzman, Jr. 2. Date of Death Month Day Year 31 Per Month On Death Cecil As Facility Name (if not institution, give street and number) 4a. Facility Name (if not institution, give street and number) 101 Washington Street 5. Social Security Number 218-46-0363 1 M 2 F 63 Yrs. 5. Social Security Number 218-46-0363 1 M 2 F 63 Yrs. 106. County Maryland Cecil North East 107. Year 1 Usual Residence of Decedent 108. Sistee 100. County Maryland Cecil North East 109. Citizen of What Country? 100. Inside City Limits 1 M 2 F 100. City, Town or Location North East 109. Citizen of What Country? 101. Washington Street 102. Was Decedent Ever in U.S. If Under 1 Year I if Under 24Hrs. Rec. American Indian, Black, White State or Country Maryland Cecil North East 109. Citizen of What Country? 100. Citizen of What Country? 101. Markial Status 1 New Markial Stat		-	- For State tegistrar	•	Certific	ate of E	eath		Re	g. No.	, ,	24070
As Facility Name (fine printed content of good and a service of go		1/	 Decedent's Name (First, Mid 									
North East South Standard Street Control	Medical Examine								July 19, 20	011		2319 hrs
S. Soos Security Number S. Soos Security N								ocation of De	ath		of Death	
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Physician Medical Stanning Physician Medical Examiner 9 23a, Part I. Effect the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arreal, shock, or heart failure. List only one cause or each inite. 23a, Part I. Effect the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arreal, shock, or heart failure. List only one cause or each inite. 25a, Part I. Effect the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arreal, shock, or heart failure. List only one cause or each inite. 25a, Part I. Effect the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arreal, shock, or heart failure. List only one cause or each inite. 25a, Part I. Effect the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arreal, shock, or heart failure. List only one cause or each inite. 25a, Part I. Effect the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arreal, shock, or heart failure. List only one cause or each inite. 25a, Part II. Effect the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arreal, shock, or heart failure. List only one cause or each inite. 25a, Part II. Effect the disease, or complications that caused of death. 25a, Part II. Effect the disease, or complications that caused of death. 25a, Part II. Effect the disease, or complications that caused of death. 25a, Part II. Effect the disease, or complications that caused of death. 25a, Part II. Effect the disease, or complications that caused of death. 25a, Part II. Effect the disease or contribution death of the cause of death. 25a, Part II. Effect the disease of cause of death. 25a, Part II. Effect the disease of cause of death.	ore, of He of Her to			on 3 Removal from St	ate crema	tory or other	place)	J	uly 21,		·	
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29b. Signature and title of certifier O.C.M.E. July 20, 2011 30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	Bo e deat the at	<u>ڇ</u>		9 Olikiowii					1			
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29b. Signature and title of certifier O.C.M.E. July 20, 2011 30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	Signature After After ar dear rector by th	힐	2 Accident Inv	estigation 28e Place of II	njury - At home, f	farm, street,	factory, office buil	lding, etc.	28f. Location (S	Street and Numb	er or Rura	al Route Number, City
29b. Signature and title of certifier O.C.M.E. July 20, 2011 30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	Div		de	uld not be			•	-	or Town, S	tate)		
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Ana Rubio MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	1/1		anet				O.C.M	.E.		July 20, 20	11	
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	11.8	t				A/ D="	one Ct 1 5	=14:	MD 24222			
111 2 9 2011 1						vv. Baltım	ore Street, B	aitimore,	IVID 21223			
		м	1111 0 0 2011	Deserve A.	a a signature							

Amended Item 23e Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 24097 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Henth 2011 OB 4:45 PM Naomi Elizabeth Hull Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Taneytown Lorien Of Taneytown e (In yrs. last birthday) 95 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country)

MD 8. Date of Birth **Funeral** 09/26/1915 **Director** 213-38-8545 Usual Residence of Decedent 28a-f show 10d. Inside City Limits ms 23a or 28a-f shor must be notified at 10a. State 10b. County 10c. City, Town or Location Director 1 ☐ Yes 2 🔀 No Taneytown MD Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21787 USA Funeral 100 Antrim Blvd. permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 🔀 No þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates. Specify: White Completed 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) ပ Marie A. Streaker Erman A. Shoemaker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
16 Cardor Ct., Baltimore, MD 21236 19a. Informant's Name/Relationship (Type, Print) 16 Cardor Ct., Baltimore, MD Elizabeth Hull/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State July 11, 11 Linwood, MD 4 ☐ Donation 5 ☐ Other (Specify) Pipe Creek Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Pritts Funeral Home & Chapel 21157 412 Washington Road, Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🔀 No 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an page 2 s autopsy performed? Yes 2 No Dementia 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) within 24 hours after death.

To the Funeral Director, After thi
completed filled in by the funeral 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) WJL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21157 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 0 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 24098 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 12. 2011 JULY AUDREY GENEVA MARSHALL HAGENS 10:15P M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner CHARLES WHITE PLAINS RESIDENCE. 9510 BLUE LAKE PLACE If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 M 2 T Months Days Hours 90 SEPTEMBER 24,1920 MARYLAND Director 216-44-9316 Usual Residence of Decedent or 28a-f shov notified at 10b. County 10c. Citv. Town or Location within 72 hours after death with the Maryland 10a. State 10d. Inside City Limits Director 1 X Yes 2 No WHITE PLAINS MARYLAND CHARLES 10e. Street and Number 10f. Zip Code ms 23a or must be r 10g. Citizen of What Country? Funeral 9510 BLUE LAKE PLACE / P.O. BOX 93 20695 UNITED STATES items 2 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Examiner Black. White, etc. 0 by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify. If Yes, Give Year or Dates "natural", Specify: BLACK 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the MAIL & FILE SUPERVISOR YEARS FEDERAL GOVERNMENT other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H JAMES GARDIE MARSHALL NORA VIOLA BUTLER MARSHALL permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FERN BROWN / DAUGHTER 4690 PICKERAL STREET, WHITE PLAINS, MARYLAND 20695 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ST. PAUL'S CHURCH CEMETERY: JULY 19, 2011 WALDORF, MARYLAND n ture of Fungral Service Licentee THORNTON FUNERAL HOME, P.A.
3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 THORNTON JOHNSON MO0583 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner Due to (or as a consequence of cause. Enter Underlying Cause (Disease or iinjury and burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the hurial Physician/Medical or Attending Physician: The law requires that the death certificate be IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death the a 1 Yes 2 L 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ merteron Deube 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed director, page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 **X** No this certificate 1 Yes 2 🗍 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 X Residence 6 \square Other (Specify) 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA completed filled in by the funeral 27. Manner of Death 1 X Natural Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred After t 5 Pending injury work? 1 ☐ Yes 2 ☐ No s after death ☐ Acciden☐ Suicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State)

Division of Vital Records, P.O. Box 68760 Hospital

State

24 hours a

To the within 2

Medical

29a. Certifier

(Check only one)

MICHAEL

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LEATHERWOOD,

5

Registrar DHMH 17 Rev 7/2009 Xcertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

M.D. 12070 OLD LINE CENTER, SUITE 302, WALDORF, MARYLAND 20604

29d. Date signed (Month, Day, Year)

JULY 14, 2011

29c. License number

D 21031

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ HORN BAKER ROINIA 2.25 AM Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death **Examiner** HAGESBWN WOSHINGEN Mesico 9. Birthplace (State or Foreign If Under Year 7. Age (In vrs. last birthday) If Under 24 Hr 8. Date of Birth 5. Social Security Number 6. Sex Funeral 1 🗆 M 2 💢 F Days Hours Min. June 1, 71921 West' Virginia 90 236-28-5595 Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location must be notified at Director 1 X Yes 2 No Hagerstown Maryland Washington 10f. Zip Code 10g. Citizen of What Country? ò 10e. Street and Number 23a 21740 U.S.A. 11 West Baltimore Street items Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14, Race - American Indian, 12. Was Decedent Ever in U.S. Examiner Armed Forces?

1 Yes 2 No Black, White, etc. 0 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🗖 No Specify: Specify: White other traumatic event, the Medical Exar. Completed 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry should be filed within 72 h and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Shockey Albert Mason Berna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau Shirley J. Lloyd Daughter|11318 Crystal Falls Road, Smithsburg, Maryland 21783 20b. Place of Disposition (Name of 20a. Method of Disposition Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place Greenlawn Memorial Pk 07-20-11 Williamsport, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee

R. hoel brody Andrew Actor Coffinan Funeral Home, Inc. 40 East Antietam Street, Hagerstown, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examiner any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last (or as a consequence of) ainomusus burial-transit Due to (or as a consequence of) attending physician Physician/Medical P.O. Box 68760 the yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death
☐ Pregnant at time of death IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown Division of Vital Records, 1 🔲 Yes filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an CHOONIC autopsy this certificate Yes 25. Was case referred to medical 26. Place of Death (Check only one) Medical Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes No Hospital: Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred s after death. (Month, Day, Year) 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or inventigation in my printing date. within 24 hours To the Funeral 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed only one) 3 🗆 29d. Date signed (Nonth, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mentu Menicol

State Registrar BALDN

31. Date filed (Month

strar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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		Registrar 1. Decedent's Name (First, Middle, La	runcate or	Death		2. Date of Dea	Reg. No.		3. Time o				
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Medica Examine		Perry Anthony 4a. Facility Name (if not institution, given	4b. City, Town,	4b. City, Town, or Location of Death				4c. County of Death					
		22680 Cedar Lan		rdtown			St. Mary's						
Funeral	П	5. Social Security Number 6.	Sex 1 X M 2 □ F	7. Age (In	yrs. last birthday,	If Under 1 Year Months Day		Min.	8. Date of Birt (Month, Day Aug • 15	th y, Year) 1921	C	irthplace (State o ountry)	-
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and 2 Health tem 2		Gertrude M. Hick 20a, Method of Disposition	ey / Wii			1 Tin To	p Scho		D, Mech			or Town, State	559
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important if filem 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.	H	1 Burial 2 Cremation 3 4 Donation 5 Other (Spe	Removal fron	n State		ematory or other p $1 {f d-Echol}$	i i	7-15	-2011	Charle	otte	Ha 11, M	D
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ling P		27. Manner of Death 1 № Natural 5 □ Pending		e of injury nth, Day, Ye	28b. Time injury	v w	ijury at ork? □ Yes 2 □	_	28d. Describe	be how injury occurred			
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Sirector: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the but	Certificate:	2 Accident Investigat 3 Suicide 6 Could no	t be 28e. Plac			street, factory, office		110	28f. Location (Street and N	lumber or l	Rural Route Nun	nber,
al or all		4 Homicide determined building, etc. (Specify)							City or Town, State)				
dospit 4 hour unera	Medical	29a. Certifier 1 Certifying P (Check 2 Medical Exa	miner: On the ha	asis of exam	nination and/or inv	estigation, in my or	oinion, death o	occurred a	it the time, date	and place, an	nd due to th	ie cause(s) and m	nanner stated
the father than 2 the father f	Me	only one) 3 Certifying N 29b. Signature and title of certifity	urse Practioner	To the bes	st of my knowledg	e, death occurred a	t the time, da	te and pla	ce, and due to tl	he cause(s) ar	nd manner	as stated. nth, Day, Year)	
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eno		AMIR KMAN, M.	ST. M	ARYU	HOSPITAL	25500 fo	INT LOT	KOUT	ROAD, L	ENARD	jours,	M3-206	:20
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Registrar
DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First Middle, Last 2. Date of Death Physician/ 25 AM Medical 4a. Facility Name (if not institution, give street an 4b. City, Town, or Location of Death Examiner County of Death 8. Date of Birth (Month, Day) **Funeral** vrs. last birthday) Hrs. 9. Birthplace (State or Foreign 1 🗆 M 2 🕱 Months Min. Country) Q 6 **Director** 10c. City, Town or Location 10d. Inside City Limits the Maryland **Funeral Director** notified 28a-f 1 🗌 Yes 2 💢 No 10e. Street and Numbe ō 10f. of What Country? 10g. Citizen must be 23a 0 items Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. or Completed by 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes Specify 3 ☐ Widowed 4 ☐ Divorced No "natural" Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1 4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle. ည enmore Informant's Name/Relationship (Type, Print) 19b. Mailing Address 860 Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 23a. Part 1. Enter th Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Mc1940MA Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of). use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): by the attending physician Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy Live Birth 2 Fetal death Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? ίο Month Day be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 : certificate has autopsy performed? Yes 2 No Yes Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 1 No ည 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 24 hours after death. 1 🔲 Yes 2 🗆 No Accident Investigation Suicide 6 Could not be 3 ☐ Suiciae 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 047044 NAKLY

Registrar
DHMH 17 Rev 7/2009

State

5-DIVISIUN

1415

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Vel 🗸

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. N 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Patricia Marewood 1:00PM ervernello Medical Facility Name (if not institution, give street and number) 4b. Citv. Examiner County of Death Montgomer Inctitutes Of 9. Birthplace (State of Foreign St. Vincent 8. Date of Birth If Unde If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 1 □ M 2 🛛 F Min (Month, Day,) April 15 Yrs ป๊953 58 Director Usual Residence of Decedent or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a -f sho amportant: In item 27 is marked other than "natural", or items 23a or 28a -f sho amportant: In item 27 is marked other than "natural", or items 23a or 28a 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director St. Christopher, Christ Church, Barbados 1 ☐ Yes 2 🛱 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral None None Barbados 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Specify: Black 1 ☐ Yes 2 X No Specify. Completed 3 Widowed 4X Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Cashier Private 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Unknown Rhonda Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Damian Harewood/Son St. Christopher, Christ Church, Barbados 20a. Method of Disposition
1 Hurial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Coral Ridge Memorial Gardens 4 ☐ Donation 5 ☐ Other (Specify) July 18,2011 Christ Church, Barbados 22. Name and Address of Facility Pope Funeral Homes, P.A. Signature of Funeral Service Licensee 5538 Marlboro Pike, Forestville, Md 20746 m01623 23a. Part & Enter he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Sepsis WEEK Medical resulting in death) Due to (or as a consequence of): Examiner 4 years cell leukemia 7 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Exami attending physician and for use as the burial-transit that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown the hed for 1 Yes 2 L 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 Yes 2 No Yes 2 No To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifics within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 \sum Yes 2 🐼 No Other: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 1 🗀 Yes 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) D0069249 Pacnel Scheraga Joly, 11, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 center prive, Bethesda, Maruland Rachel Scheraga MD 20892

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day,

5 2011

Baltimore, Maryland 21215-0036

68760

Box

P.O.

Records,

of Vital

Division

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month MARJORIE BERNADEAN **HEDLESKY** 19 2011 $\tt JULY$ 1:30 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death PR. GEORGE'S HOSPITAL CENTER CHEVERLY GEORGE 'S PR. 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months AUG 2, 1 □ M 2**x** Hours 1924 INDTANA 86 Director 309-20-9416 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f sho must be notified at Director 1 Yes 2 X No MD CHARLES WALDORF 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1012 ST. PAUL'S DRIVE 20602 U. S. A. items ; death \ 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status er than "natural", or ite the Medical Examiner Armed Force Black, White, etc. 1 Never Married 2 Married δ 1 ☐ Yes 2 🙀 No If Yes, Give Year or Dates. Maryland 21215-0036 hours after 1 Yes 2XXNo Specify Specify: WHITE Completed **¾**XWidowed 4 □ Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) t. Page 1 and 2 should be filed withintent of Health and Mental Hygiene trant: If item 27 is marked other the jury or other traumatic event, the SECRETARY ELEMENTARY SCHOOL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ FLOYD H. MILLER GLADYS MARY JOHNSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ANTHONY HEDLESKY / SON 5005 PUPFISH CT., WALDORF, MD 20603 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot JULY 1 Durial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) TRINITY MEM. GRDNS. 26,2011 WALDORF, MARYLAND 21. Signature of Funeral Service Li 22. Name and Address of Facility RAYMOND FUNL. SERVICE, P.A. M00641 5635 WASHINGTON AVE., LA PLATA, MD 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death MASSIVE STROKE Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner RIGHTINTERNAL CAROTIS ART OCCILVSION OF Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Examine sician and burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) nding physician use as the burial Physician/Medical death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death asn 23b. Was decedent pre**g**nant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ atten for u in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year 1 Yes 2 9 Unknown the per P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records. 1 Yes 2 No 3 Probably 4 Unknown Completed neec 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 page performed^a certificate 1 Yes 2 No e Hospital or Attending Physician: 124 hours after death.

Funeral Director: After this certific Division of Vital 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 🗌 Yes 2 No ၉ 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Marse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one within To the 29b. Signature and title of certi-29c. License number 29d. Date signed (Month. Day, Year) 2 D40386 Jr 44 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

3001

32. Registrar's Signature

COOPER

CARNELL
31. Date filed (Month, Day, Year)

JUL 28 2011

HOSPITAL DR. CHEVERLY MI)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Andrew Hall		1- For State Registrar		tate of Maryla		partmen <i>Certificate</i>			Menta		Reg	. No.	2011	24104
Physicia Medical Examin		1. Decedent's Name	e (First, Midd		w J.	Ha11				Mo	nte of Death	Day	Year	3. Time of Death 1305 hrs
medical Examin		4a. Facility Name (i	f not instituti	on, give street and nu		патт	4b	City, Town, or Lo	ocation of I		y 17, 20		ounty of Deatl	
		Mt. Zoar bo	at ramp					Conowingo				Cec	il	
Funeral Director		5. Social Security N		6. Sex	7. Age (In yi	rs. last birthda	y) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	ate of Birth 06/21/		Foreig	thplace (State or enPennsylvania ountry)
any	ŀ	Usual Residence of 10a. State	Decedent 10b. County		I10c (ity, Town or L	ocation							10d. Inside City Limits
B		Maryland	,	ford		Havre								1 XYes 2 No
faryland 28a-f show Latouce	Director	10e. Street and Nur		.1014		HUVIC		Of. Zip Code			10g	. Citizen	of What Cou	ntry?
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21215-0036 Juld be filed within 7 Mental Hygiene. Marked other than to event, the Medisa	8	Edwin P.							Marga	aret A	A. Tay	or 1		
Should and Me]٤	19a. Informant's Na					-	ddress (Street a					, ,	, ,
and 2 sho ealth and traumati	ŀ	Mark S.		Brother	20			olton Ro					1981(ation - City or	
Baltimore, MD permit. Pages I and 2 sh Department of Health and Important: If item 27 is injury or other traumal	1			n 3 Removal fro		crematory of	or other	place)		Ju1y 2 2011	6,		•	, -
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De per De m	d	None	ر للا	S. trul				103 W. S	tockt	on St	reet,	E1k	ton, M	D 21921
Physician	T	23a. Part I. Enter the failure. List onl	e disease, or y one cause	complications that ca on each line.	used the de	ath. Do not en	ter the	mode of dying, su	ich as card	liac or respi	ratory arres	t, shock,	or heart	Approximate Interval Between Onset and
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Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed bin 24 hours after death. The Funeral Director: After this certificate has been signed by the attending physician and pipelety filled in by the funeral director, page 2 should be detached for use as the burial transit.	Medical	X UNPENDED		d AMENDED 2	3a,27	,28a−f	per	me,g917	7-29	9-11 s	m			
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ox 6876 eath certificate attending phy for use as the	ian	23b. Was decedent p past 12 months		1 Live b		2		death 3	Ectopic pr	regnancy		Moi		Day Year
Box 68760, a death certificate be the attending physic ed for use as the burners.	Physician/	1 Yes 2 N	lo 9 Uni	known 9 Unkno		death 5	Other	(Specify)						
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aw requires as been signal of 2	Bet					· · · · ·	_			_ 2	4a. Was an autopsy		prior to c	topsy findings available completion of cause of
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Divi: To the Hospital or / within 24 hours after To the Funeral Dire completely filled in b	io I	(Check only ' L		hysician: To the besi miner:On the basis of and manner st	f examinatio									
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		Pame	le STA	uthall, n	11)			O.C.M.	E.		\	July 18	, 2011	
B		30. Name and addre Pamela E. S		who completed caus ID Assistant I			900 V	V. Baltimore S	Street, B	altimore,	MD 212	23		
Sta Registr	te ar	31. Date filed (Monti	2011	Deven 32. Re	gistrar's Sign	How								
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State of Maryland / Department of Health and Mental Hygiene 20 | |

			For State Registrar		aryland / Depa Cer	tificate of L		_	Reg. No.	1	24105	
	Physicia		1. Decedent's Name (First, Middle, Last) John Ken					2. Date of De Month July 6	Day Y	/ear	3. Time of Death 11:00 P ^M	
	Medic Examin		4a. Facility Name (if not institution, give s			4b. City, Town, o	r Location of De		4c. County of	Death	11.00 1	
1	Funeval		Manor Care of Be 5. Social Security Number 6. Sex		e (In yrs. last birthday)	Bet If Under 1 Year	thesda If Under 24 F	Irs. 8. Date of Bir	Mont		ace (State or Foreign	
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21215-0036 within 72 hours after death with the Mandand	ryland -f show ied at	Director	10a. State 10b. County		10c. City, Town or Loc	cation	D 1-			10	0d. Inside City Limits	
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	h with his 23a must b	Funeral	809 Baltimore Ro	oad			851		United		,	
	e filed within 72 hours after death with the Maryland tal Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ♣ Yes 2 ☐ If Yes, Give Year or Dates.	No	Vas Decedent of H Yes, specify Cuba ☐ Yes 2 🌣 No		(Specify Yes or No- erto Rican, etc.)	14. Race - Black, Specify:	America White, e Bla	tc.	
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lary	should and M is ma aumat		19a. Informant's Name/Relationship (Typ		19b. Mailin	Margaret Brandford 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co						
	1 and 2 should be f of Health and Menta item 27 is marked other traumatic ev		Rosalind P. Oden -	- Daughter	20b. Place of Dispos	6th Stre	et NE	Washingto		0019	- 01-1-	
	Page 1 nent of ant: If if ury or c		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	cemetery, crem	catory or other place	1 1111	Ly 14, 2011	20c. Location - Ci	•	faryland	
Baltimore,	permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr		21. Signature of Fungial Service Licen e	towar	132 22	. Name and Addres	ss of Facility	Stewart F	uneral Ho	me,	Inc.	
			23a. Part Enter the disease, or complishock, or heart failure. List only one	cations that caused	the death. Do not ente				hington, rest,		20019 Approximate	
F	nysician/ Medical		Immediate Cause (Final disease or condition resulting in death)		onary Artei	y Diseas	se				Interval Between Onset and Death	
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	cate be executed physician and the burial-transit	dical		l								
20x 687	v requires that the death certificate be to been signed by the attending physici should be detached for use as the bu	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at	2 🗌 Fetal death 3 🗀	Ectopic pregnanc	y		23d. Date o		y Day Year	
Э. Э.	at the c d by th letache	Phys	9 ☐ Unknown Part II. Other significant conditions con	9 Unknown	at not resulting in the ur	nderlyina cause aiy	ven in Part I	220 Did to	obacco use contribu	ita to tha	ogune of death?	
ds, F	quires th en signe ould be c	ted by	•								ably 4 Unknown	
DIVISION OF VITAL RECORDS,	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached.	Completed						24a. Was a autop perfor	prio prio prio prio dea	r to com	sy findings available pletion of cause of	
[2]	ician;	Be	25. Was case referred to medical examiner?	ospital:			ace of Death (Cf		212-1101	1 165 2	. 🗀 110	
OT 0	g Phys er this eral dir	e: 10	27. Manner of Death			28c. Injury	4 L Nursing / at		lence 6 Other (some own injury occurred	Specify)		
00	tending leath. tor: Afte the fun	Certificate:	1 X Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be		(ear) injury work? M 1 Yes 2 No							
	al or At s after or Il Direct ed in by		4 Homicide determined	28e. Place of Injurbuilding, etc.		- At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	e Hospii 24 hour e Funera leted filli	Medical	29a. Certifier 1 Sertifying Physic (Check 2 Medical Examine 2 Certifying Nurse)	r: On the basis of ex	amination and/or investi	gation, in my opinio	n, death occurre	d at the time, date as	nd place, and due to	the caus	e(s) and manner stated	
:	vithin Vithin Comp		29b. Signature and title of certifier		est of my knowledge, d	29c. License	number		29d. Date signed (N	1onth, Da		
			P	lasse			1057	124	7/13	111		
r	1		30. Name and address of person who cor Truong Bao, MD 1		ath (Item 23a) (Type, Pr cular Driv		206 Roc1	kville. M	d. 20850)		
100	State Registra	e r_	31. Date filed (Month, Day, Year) JUL 1 5 2011		's Signature				2.23			

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician /Medical no15 Tiner arson 2011 JUN 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) June 18, 2003 Birthplace (State or Foreign Country) **Funeral** 1 🗶 M 2 🗆 F 8 482-33-0221 Iowa **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show r than "natural", or Items 23a or 28a-f sho the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Directo New Windsor Maryland Frederick 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 3203 Sams Creek Road 21776 United States death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Iter any Injury or other traumatic event, the Medical Examiner ones. 1 X Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☐XNo If Yes, Give Specify: Completed by 3 Widowed 4 Divorced White Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Elementary School Student 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Kaarina Vuohijoki Keith Koistinen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Keith Koistinen/Father 3203 Sams Creek Road, New Windsor, MD 21776 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Apostolic Lutheran
Cemetery 20a. Method of Disposition 20c. Location - City or Town, State Ju1y 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2011 Lake Norden, SD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, MD 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Hyporic Tschemic Brain
Due to (or as a consequence of): /Medical Examiner Due to (or as a consequence of): Unresectable Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner attending physician and for use as the burial-transit that initiated events death certificate be execu resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy funeral director, page 2 should be detached for in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) 2 🗌 No P.O. 9 Unknown the 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Division of Vital Records, 2 No 3 □ Probably 4 □ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? 2 No 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 ☐ Yes 2 ☐ No Hospital: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ည 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred 27. Manner of Death s after death. Certification: 1 Natural 5 Pending investigation Injury 1 🗌 Yes 2 No 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) 4 - Homicide To the Hospital within 24 hours a To the Funeral C 1 SertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of cortife 29c. License number **RES** - 000 July 20, 2011

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State Registrar Rajeev

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

600 North Wolfe St, Baltimore, MD, 21287

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Wadio

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 07 Mary Catherine Lyons 2011 11:15 p^M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Dennett Road Manor Nursing Home 0akland Garrett If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 Days Hours (Month, Day, 28 Country) 1941 Director 69 214-28-6466 Usual Residence of Decedent shov 10a. State and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f sho raumatic event, the Medical Examiner must be notified at 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 🗶 Yes 2 🗌 No MD Garrett Kitzmiller 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 246 W Main St USA 21538 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Force Black, White, etc 1 Never Married 2 Married ģ ☐ Yes 2 X No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Yes, Completed Specify: 3 X Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Garrett County Roads equipment operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charles Broadwater Edna Carr t. Page 1 and 2 should b tment of Health and Mer rant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 256 W Main St, Kitzmiller, MD 21538 injury or other Kathy Armstrong-daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 🗆 Burial 2 🕱 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cumberland Crematory 7/18/2011 Cumberland, MD 21. Signature of Funeral Service License 22. Name and Address of Facility David A. Burdock Funeral Home PA Oakland, MD 21550 N 2nd St, 23a. Part 1. Enter the disease, or complications that caused the death. D. shock, or heart failure. List only one cause on each line. enter the mode of dying, such as cardiac or respiratory arre-Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Iva Vivel disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Due to for as a consequence of burial-transit Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): physiciar Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 as the the attending IF FEMALE for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death signed by the a 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 1 Yes page 2 should After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe Physician: The 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ျပ 1 Tyes 2-No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred or Attending (Month, Day, Year) injury Natural 5 Pending death. Accident 1 Yes 2 No Investigation within 24 hours after death To the Funeral Director: A completed filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined the Hospital Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 0

DHMH 17 Rev 7/2009

State

Registrar

Thomas G. Johnson, M.D., 311 North Fourth St, Suite II, Oakland, MD 21550

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

31. Date filed (Month, Day, Year)

18 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend Item 24a per med cert G918 8/11/11 dk
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death July Physician/ 2011 Mc Cauley 9:50 Ruby Lorraine Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 20014 Rosebank Way #111 Hagerstown Washington If Under 1 Year If Under 24 Hrs.
Months Davs Hours Min. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) ent. 14,1937 1 M 2 X Months Maryland Director 73 Sept. 214-34-0231 Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD 1 ☐ Yes 2 🗓 No Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral with 1 20014 Rosebank Way #111 21740 U.S.A. and 2 should be filed within 72 hours after death Health and Mental Hygiene. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛱 No Specify: If Yes, Give Year or Dates Specify: White 3 Wildowed 4 Divorced Completed ed other than "nature event, the Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Many injury or other traumatic event, the Monea. Elementary/Seconday (0-12) College (1-4 or 5+) Nurse Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ Clarence Edward Mace Hazel Jane Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20014 Rosebank Way #111, Hagerstown, MD 21740 Carl L. McCauley/Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 7/21/2011 Hagerstown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 5 Min 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Breast Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated events Examine Due to (or as a consequence of) that the death certificate be executed the attending physician and Due to (or as a consequence of): resulting in death) Last Physician/Medical 68760 the IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box (3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? page 2 should be detached for Month Year Day 4 ☐ Pregnant at time of death 9 ☐ Unknown g 🗌 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ or Attending Physician: The law requires Division of Vital Records, Coronary Artery Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Diabetes Mellitus has autopsy performed? this certificate Hypertension 1 Yes Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Yes 2 X No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 \square Nursing Home 5 X Residence 6 \square Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Director: After 1 X Natural 5 Pending work? 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital or within 24 hours aff To the Funeral Di Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge th occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certif 29d. Date signed (Month, Day, Year) 7/18/2011 D0066930 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 13424 Pennsylvania Ave. Suite 203, Hagerstown, MD 21742 JW-6 Ann DeClue MD

State

Registrar

31. Date filed (Month, Day

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T = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Moreth Moreth										3. Time of Death	
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, , , , , , , , , , , , , , , , , , ,	Examin	er	4a. Facility Name (if not institution, give stre 62 Drumcastle Cour			4b. City, Town, or Germant	Location of Death		4c. County of Monts	of Death gomery	
0	Funeral Director		5. Social Security Number 6. Sex 1 X1		rs, last birthday) 31 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Dec 12	(°1'929	9. Birthplace (State or Foreign Country) Japan	
	d fr	L	Usual Residence of Decedent 10a, State 10b. County	100	. City, Town or Loc	ation				10d. Inside City Limits	
	larylar 3a-fsh ified a	Director	Maryland Montgomer		Germanto					1 ☐ Yes 2 😾 No	
	nthe M aor 28 be not	al Dir	10e. Street and Number			10f. Zip Code	20276		g. Citizen of W	1	
	ath with	Funeral	62 Drumcastle Cour	. Was Decedent Ever in	IIS II3 W	/as Decedent of Hi	20876 ispanic Origin? (Sp		Jnited S	- American Indian,	
920	e filed within 72 hours after death with the Maryland that Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	1 Never Married 2 Married 3 😾 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.	lf	Yes, specify Cuba ☐ Yes 2 X No	n, Mexican, Puerto	Rican, etc.)		White	
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212	iled within 7 Il Hygiene. I other than vent, the M		Elementary/Seconday (0-12)	College (1-4 or 5+)		,	astern Eu			lines	
Maryland 21215-0036	be filed vental Hygreked other	To Be	17. Father's Name (First, Middle, Last) Boris Markaroff		•			ne (First, Middle, Ma	-		
fary	ge 1 and 2 should be file it of Health and Mental F I fitem 27 is marked o or other traumatic eve		19a. Informant's Name/Relationship (Type,			-		al Route Number, C	-		
e, N			Alicia D. Connolly 20a. Method of Disposition		b. Place of Dispos	Fire Fa	- T	Murietta Date 2		A 92562 ation - City or Town, State	
<u>m</u> o	Page 1 nent of ant: If i		1 X Burial 2 ☐ Cremation 3 X Read 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	cemetery, crem D 1ivewoo d	atory or other place Cemeter	^(e) Ju1 y 20	y 22,		ide, CA	
Baltimore,	permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other once,		21. Signature of Funeral Service Licensee	bug (MO)			ss of Facility De er Park	Vol Funer Dr. Gait		e rg, MD 20877	
П			23a. Part 1. Enter the disease, or complica shock, or heart failure. List only one c	tions to at caused the cause on each line.	death. Do not enter	r the mode of dyin	g, such as cardiac	or respiratory arres	t,	Approximate Interval Between	
	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	Malignant Due to (or as a cons		n of the	Larynx			Onset and Death	
	Examiner	L	Sequentially list conditions, b.	Due to (or as a cons	sequence on.						
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	cate be executed physician and sthe burial-trapsit	l Exa	that initiated events c. resulting in death) Last	Due to (or as a cons	sequence of):						
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687	certifica nding p	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c	If yes, outcome of pre			23d. Date	e of delivery			
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P.O.	s that the	by Pl	Part II. Other significant conditions contri	buting to death but not	t resulting in the ur	nderlying cause giv	ven in Part I.			bute to the cause of death?	
rds,	require been signature	eted								3 Probably 4 Unknown	
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tal F	sian: Ti ertificat ctor, p	Be C	25. Was case referred to medical examiner?				ace of Death (Chec	1 Yes 2	A NO	res 2 no	
ř Vi	Physic r this or ral dire	은	1 Yes 2 No	pital: 1 lnpatient 2 28a. Date of injury	2 ER/Outpatient	t 3 DOA Othe	4 □ Nursing H	ome 5 X Resider 28d. Describe how			
on c	ending eath. rr. Afte	ficate	1 X Natural 5 Pending 2 Accident Investigation	(Month, Day, Year	r) injury	work	? Yes 2 \Begin{array}{c} No	Zod. Describe nov	i injury occurron		
Division of Vital Records,	al or Attending Physician: The law s after death. Is after death. In the funeral director, page 2 and in by the funeral director, page 2.	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - A building, etc. (Spe	at home, farm, stre ec <i>ify)</i>	et, factory, office		28f. Location (Stre City or Town,		r or Rural Route Number,	
The coronal of the first of the								to the cause(s) and manner stated.			
	Nothing Within		29b. Signature and title of certifier			29c. License			d. Date signed	(Month, Day, Year) 3, 2011	
			30. Name and address of person who comp				Suite 10	0 Rockv	ille, M	D 20850	
	Sta Registra		31. Date filed (Month, Day, Year) 31. 14. 2011	32/Registrar's Si	gnature for	Ked					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2 State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2011 Physician/ July Marjorie L. Meschket 1:46 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Lorien Nursing Home Taneytown Carroll If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 MD 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth Months MD 10/30/1922 Director 216-14-0439 88 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 💆 No MD <u>Carroll</u> Taneytown ŏ 10e. Street and Numbe 10g. Citizen of What Country? ral", or items 23a or Examiner must be Funeral USA 21787 6175 Taneytown Pike 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes : If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. "natural", Completed 3 Nidowed 4 Divorced White Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 12 Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Benjamin Franklin Bauer Sr. Marion Clagett permit. Page 1 and 2 should by Department of Health and Mer Important: If item 27 is marku any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6175 Taneytown Pike, Taneytown, MD 21787 Tegeler-daughter <u>Janet L.</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Moreland Memorial 07/11/11 Parkville Sonatu of In In Gervie Licensee ^{22. Name and Address of Facility}Fletcher Funeral Home, 254 E. Main St. Westminster, MD 21157 Part 1. Enter the disease, or complications that caused shock, or head failure. List only one cause on each line ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ disease or condition resulting in death) weeks Medical Due to (or as Examiner mass Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Examine transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): burialphysician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death Day signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be Completed 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page. performed?
1 Yes 2 No this certificate 25. Was case referred to medical director. Be 26. Place of Death (Check only one) examiner? 1 Tes 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify, To the Hospital or Attending Pt within 24 hours after death.

To the Funeral Director: After the completed filled in by the funeral the funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At hor building, etc. (Specify) At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State, Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) WIL 5 death (Item 23a) (Type, Print estminst

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day,

32. Regis

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 2011 Year Bob Mack Moore 11 11:20 a M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll 566 Rich Mar Street Westminster 5. Social Security Number '. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗷 M 2 🗆 F Months Davs Hours Indiana 304-22-4229 86 Director Usual Residence of Decedent 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director notified Bradenton Florida Manatee 1 🗌 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 must be Completed by Funeral 34210 23a 4834 Independence Drive USA "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian. rmed Forces?
Yes 2 \(\subseteq \text{No} \) Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: If Yes. Give white 3 Divorced WWII Year or Dates. event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Savings & Loan Finance Dept Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Nathan Moore ပ္ Nellie Willman other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Rae Moore, wife of Health 4834 Independence Drive, Bradenton, FL 34210 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Soleter) Crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a
Department of IImportant: If ite
any injury or ott ☐ Burial 2 X Cremation 3 ☐ Removal from State 07/13/2011 Carroll Crematory Winfield, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Myers-Durboraw Funeral Home 91 Willis Street, Westminster, MD 21157 2 23a. Part 1 Enter the disease, or complications that reused the death. Do not enter the shock, or heart failure. List only one cause on each line. de of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) the attending physician and hed for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death 1 Yes 2 9 Unknown 4 ☐ Pregnant 9 ☐ Unknown After this certificate has been signed by funeral director, page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\sum \) Yes \(2 \sum \) No 24a, Was an autopsy performed th. After this certificate I 1 Yes 2 2 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 Nother Specify Home Other: ျ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 🗌 Yes 2 🗎 No 28d. Describe how injury occurred 1 Natural iniury 5 Pendina To the Hospital or Attendition within 24 hours are refer the To the Funeral Director A completed filled in by the fi Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Lertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature at 29d. Date signed (Month, Day, Year) WJL IOTIVA

Registrar DHMH 17 Rev 7/2009

State

SOUTH

CENTER STREET.

WESMINSTER MD.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KRUTER

31. Date filed (Month, Day, Year)

M.D

555

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 20 | 24 | 2 State of Manyland / Department of Health and Mental Hygiene

 7			
State of Maryland	Department of He	ealth and Mer	ntal Hygiene

			I- For State Registrar		Certifi	cate of D	eath		1	Reg. No.	
	hysici	an/	Decedent's Name (First, Middle			Ma			2. Date of De Month	Day Yea	3. Time of Death
Medical	Exami	ner	Steven	P	Martin der) 4b. City, Town, or Location of Death			July 11, 2	2011 4c. County of	" 0633 hrs	
			4a. Facility Name (if not institution Southern Maryland Ho	-			City, Town, o Clinton	Location of	Deam	Prince G	
E.	unerai		5. Social Security Number		e (In yrs. last b		If Under 1 Ye	ar If Under	24Hrs. 8. Date of B		9. Birthplace (State or
	rector			1XM 2F			Months Day	_	Min	31-71	Foreign Wæ sh ningtonD(
			214-06-2442 Usual Residence of Decedent		39	115.		Ш	10	51-71	Washingtone
	any.	Ì	10a. State 10b. County		10c. City, Tow	n or Location					10d. Inside City Limits
pu	sbow ice.	_	Maryland Prin	ce George	Upr	er Ma	rlbor	0			1 X Yes 2 No
faryla	28a-f show i at once.	ect	10e. Street and Number	100 0001 90			0f. Zip Code			10g. Citizen of Wh	nat Country?
the	Sa or	급	4800 Copley I	in, Apt. 28	30		2077	2		US	A
h with	be n	Funeral Director	11. Marital Status	12, Was Decedent	Ever in U.S.				n? (Specify Yes or N Puerto Rican, etc.)	o- 14. Race White	- American Indian, Black,
r deat	or ite	튑	1 Never Married 2 Ma	1 Yes 2	K No				, 45,10 . 11.54., 510.,		
s afte	niner,	ð	3 Widowed 4 Dive	orced If Yes, Give Yeer or Dates:	plotod) 160	1 Ye		specify:	ind of work done	Specify: 16b. Kind of Bu	Black
2 hour	"natı Exar	Completed	Elementary/Secondary (0-12)	College (1-4 or 5			of working life			Tob. Mild of Ed	aniesa/industry
36 hin 7	e. than	g e		4			Elde	r		Ch	urch
5-06 wiv	lygier other	5	17. Father's Name (First, Middle,	Last)		-			Name (First, Middle,	Maiden Surname))
21. % fil	riked rent,	Be	Fletcher	V. Martin	Sr.			Alio	ce		Martin
2 hould	is ma	. – .	19a. Informant's Name/Relations								n, State, Zip Code) 200772 arlboro MD
M M	alth a		Traci Martin,	/Wife		800 C			Apt 280,1		City or Town, State
5 1 a	of He		1 Burial 2 Cremation	3 Removal from Sta		atory or other					
in Bag	tant:		4 Donation 5 Other Sp	pecify:	Resu	ırrect			7/19/11	Clint	on,Maryland
Ball	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	J	21. Signature of Funeral Service	Licensee			e and Addres		Hama Da	7 ~ 11 2 C G	o MD 20608
	sician	-	23a. Part I. Enter the disease, or	complications that caused	the death. Do	not enter the r	node of dving	Such as ca	rdiac or respiratory ar	rest, shock, or hea	o MD 20608 Approximate Interval
	edical	-	failure. List only one cause	on each line.							Between Onset and Death
£xa	miner		Immediate Cause (Final disease or condition resulting in death)	a. Hypertensive At		ic Cardiov	asculai Di	sease			
			Sequentially list conditions,	b							
		<u>ē</u>	if any, leading to immediate cause. Enter underlying cause	Due to (or as a conse	equence of):						
		Examiner	(Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conse	quence of):						
scuted	and			d							
Sox 68760, death certificate be executed	physician and the burial - transit	Medical	UNPENDED	AMENDED							
760, ficate b	g phys		IF FEMALE: 3b. Was decedent pregnant in th	23c. If yes, outcom	ne of pregnanc		donth 3	Ectopic	predpancy	23d. Date of Month	delivery Day Year
Box 68 e death certif	endin use a	Sa	past 12 months?	4 Pregnant at	time of death	2 Fetal of 5 Other	(Specify)		programoy	l lillonian	Say Tour
B0)	has been signed by the attending 2 should be detached for use as	Physician/	1 Yes 2 No 9 Unk	9 Unknown							
hat th	ed by letach	P P	Part II. Other significant conditi	ions contributing to death	but not result	ng in the unde	erlying cause	given in Parl			bute to the cause of death? Probably 4 V Unknown
S, F	n sign Id be	8							_		I con recent to the second
ord W reg	has been 2 should	품							24a. Was	psy p	Vere autopsy findings available rior to completion of cause of eath?
Rec The l	cate h	Completed								2 No 1	Yes 2 No
Division of Vital Records, P.O	his certificate director, page	BB	25. Was case referred to medical examiner?	11 3 1				<u> </u>	Check only one)	1 5	7
F Çi	ral din	ટ	1 Yes 2 No 27. Manner of Death	1 III III palle	nt 2 🗸 ER/	Outpatient 3 Time of Injur		ry at Work?		Residence 6	
O La Ging	h. After funera	<u>ë</u>	1 Natural 5 Pend	28a. Date of Inju (Month, Day,Yo		. Time of linjur		yes 2∏ 1		Thow injury occurre	eu
Sio	after death. Director: d in by the i	<u>s</u>	2 Accident Inves	stigation	urv - At home	farm street fa				Street and Number	er or Rural Route Number, City
Div	rs afte	Certification:		mined (Specify)	.,	,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	0,	or Town,		
Division of Vital Records, P.O. I To the Hospital or Attending Physician: The law requires that the	within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral	5	20a Cartifier	nysician: To the best of my	knowledge, d	eath occurred	at the time, d	ate and plac	e, and due to the cau	se(s) and manner	as stated.
o the	To the	Medical		miner: On the basis of exar and manner stated.	nination and/or	investigation,	in my opinior	n, death occu	urred at the time, date	and place, and du	ue to the cause(s)
A F	≥ ⊨ 3	Me	29b. Signature and title of certifie				29c. Licens	se number		29d. Date signe	ed (Month, Day, Year)
			Cenol	Helle			O.C.	M.E.		July 12, 20	11
201			30. Name and address of person						ND 64555	•	
165			Carol Allan, MD Ass 31. Date filed (Month, Day, Year)	sistant Medical Exan		W. Baltim	ore Street	, Baltimor	e, MD 21223		
				32. Registrar	's Signature						

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 4 2 Date of Death Physician/ 0208M Dorothy Virginia Miles Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Hagerstown Washington Meritus Medical Center Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthdav 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 91 March 23, 1920 217-18-8591 West Virginia **Director** Usual Residence of Decedent ms 23a or 28a-f show must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington Hagerstown Y Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21740 11 West Baltimore Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Armed Forces Black, White, etc. þ 1 Never Married 2 Married Yes, Give 2 X No Baltimore, Maryland 21215-0036 white 1 Yes 2 No Specify: Completed 3 Nidowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) hospital laundry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Harry Franklin Clark Elizabeth Virginia Barnes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 Hearthside Lane, Greencastle, Pennsylvania 17225 David G. Miles - son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Cemetery, crematory or other place)
Cedar Lawn Memorial
Park 1 X Burial 2 Cremation 3 Removal from State $\frac{21}{2011}$ 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, Maryland 21. Signature of Funeral Servi 22. Name and Address of Facility Minnich Funeral Home East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) the attending physician and hed for use as the burlal-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day Year 1 ☐ Yes 2 ☐ 9 ☐ Unknown detached Unknown signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No ours after death.

eral Director, After this certificate if filled in by the funeral director, page Bradycard 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' 2 1 No Other: 1 🗆 Yes ٩ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital within 24 hours a To the Funeral D Hospital Certifying Phy ici in: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Example: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Gentlights Nurse Practicine: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2011 D0057285 30. Name and odress of rerson who completed cause of death (Item 23a) (Type, Print) Koilpill 4102

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. for State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month envietta July 14, 201Î 4:08 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Charles Charles County Nursing Center LaPlata Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Funeral 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 🗆 M 2 🗶 F Days Hours Min 08/10/1918 Maryland Yrs Director 578-09-0216 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director notified Maryland Charles La Plata 1 Yes 2X No 10e. Street and Number 0 10f. Zip Code 10g. Citizen of What Country? ms 23a o must be Funeral 9608 Springhill Newtown Road 20646 USA items ? and 2 should be filed within 72 hours after death wealth and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or iten edical Examiner r 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. Completed by 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: Specify: White 3 X Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Bookkeeper Furniture Company Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Charles C. Wood, Jr. Fowler Mignonnette 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela M. Heid Daughter 9271 Alyssum Way Annandale, VA 22003 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🗷 Burial 2 🗆 Cremation 3 🗀 Removal from State cemetery, crematory or other place) Cedar Hill Cemetery Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 07/27/2011 21. Signature of Funeral Service Lice See Mattingley-Gardiner Funeral Home, P.O. Box 270 Leonardtown, MD 20 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final adenocalcinoma Onset and Death letastatic Prnysician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine signed by the attending physician and detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Division of Vital Records, P.O. Box in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year 9 Unknown Part II. Other significant conditions contributing to death 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown After this certificate has been significate has been significated function, page 2 should the page of the state of the sta 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: ည 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Sursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending Accident 3 Sulcide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 2011 30. Name and address of person who completed dause lause of death (Item 23a) (Type, Print)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. N2 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Year **Physician** MCENTEE 0710 AM ANE 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore** 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕅 F 054-20-9161 85 New York, Director March 26. Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Director MD Montgomerv Rockville 10e. Street and Number 10f. Zip-Code 10g Citizen of What Country? 701 King Farm Blvd. Funeral #766 20850 **USA** 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 [X] No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 🗷 No \$ Specify Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Travel Agent Travel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jane Murphy ည Harold Brady 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jane A. Brady/Niece 26 Coolidge St. Brookline, MA 02446 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Cem 9/22/11 Arlington, VA 21. Signature of Funeral Service Licen 22. Name and Address of Facility 22203 marke Sum Murphy Funeral Home 4510 WilsonBlvd. Arl., VA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a cons quence of): Examiner cid Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed lcian and burial-trans Due to (or as a consequence of) Box 68760. attending physician Physician/Medical as the l IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 ☐ Ectopic pregnancy Day Month Year Pregnant at time of death 5 Other (specify) the Division of Vital Records, P.O. 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? \$ Completed 1 🗌 Yes No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 4 \sum Nursing Home Hospital: 1 Xippatient 2 \square ER/Outpatient 3 🗆 DOA ဂ 5 Residence 6 Other (Specify) this filled in by the funeral Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 24 hours after death. E Funeral Director: After or Attending 1 Natural 2 Accident 5 Pending investigation Injury 1 □ Yes 2 □ No Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in reversi 29a. Certifier Medical (check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the I within 2 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) RES-000 15 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 1/2001

State

NDR

31. Date filed (Month, Day, Year)

EW

HUGHES

4940 Eastern Avenue, Baltimore, MD, 21224

MI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. N2 0 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 13,2011 Barbara Marable 1220 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Prince Georges Hospital Center Cheverly Prince Georges 5. Social Security Number **Funeral** Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Days (Month, Day, April 5 1 M 2 J Months Hours Min. 243-78-1312 Henderson, **Director** 65 Usual Residence of Decedent 28a-f show aţ 10a, State 10b. County with the Maryland 10c. City. Town or Location Director 10d. Inside City Limits must be notified 1 Yes 2 No Prince Georges Maryland | Fort Washington ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 12007 Bion Drive 20744 United States death v 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Examiner 14. Race - American Indian Armed Forces ori 1 X Never Married 2 Married Black, White, etc. þ Yes 2 No Maryland 21215-0036 72 hours after 1 ∟ Yes a If Yes, Give Black "natural" 1 Yes 2XXNo Specify 3 Divorced 4 Divorced Specify: Completed Year or Dates than "nature he Medical E 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) DC Department of Parks Elementary/Seconday (0-12) College (1-4 or 5+)
Four Years Hygiene. age 1 and 2 should be filed within ent of Health and Mental Hygiene nt: If item 27 is marked other th. ry or other traumatic event, the. the Twe1ve Recreation Specialist & Recreation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Joel C. Marable Willie Alice Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sonia R. Marable/Sister 6141 Naval Avenue, Lanham MD 20706 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State July 23. 1X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place. permit, Page Department of Important: If any injury or Harmony Memorial Park 2011 4 ☐ Donation 5 ☐ Other (Specify) Landover Maryland Signature of Funeral Service Licenses 22. Name and Address of Facility Robert G Mason Funeral Home Inc Donald R. 1661 Good Hope Rd SE Washington DC 20020 23a. Part 1. Enter the disease, or con s, that caused the eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only on each line Interval Between Immediate Cause (Final Onset and Death Ph sician/ SepticeMa disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Small Bowel Fistula Sequentially list conditions Examiner if any, leading to immediate Due to (or as a consequence of). sician and burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year 2X No Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Salral Ulcer Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4x Unknown been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? Respiratory Failure has autopsy After this certificate performe Yes 2X No 1 🗌 Yes 2 🗴 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2 No. Other: မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending injury neral Director: A filled in by the fi Accident
Suicide Investigation 1 Yes 2 No 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined within 24 hours a

To the Funeral C

completed filled Medical 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0026024 July 13,2011

Su

Registrar

State

31. Date filed (Month, Day, Year)

JUL 28 2011

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Lester Miles M.D. 1160 Varnum Street NE, Washington DC 20017

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year (Y)ichae! 30005 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Funeral Days Hours Min. 1 M 2 □ F Country) Director 220-38-067 Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho amy injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No 10e. Street and Number 0000000 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🔀 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ၉ Circhie Scott Marvin pole 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marvin picles 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) mbedon Mon Signature of Funeral Service Licenses 22. Name and Address of Facility McKenzie Funed Home PA ECEL MOIN STIDEL 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause — each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or as a nsequence of Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence oi). and I-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) physician a the burial-t Physician/Medical Box 68760 signed by the attending plants and be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Month Year Pregnant at time of death Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 Yes 2 No 3 Probably 4 Unknown should I Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has t lirector, page 2 s performed Yes 2 🗷 1 Yes 2 🗌 No Division of Vital 25. Was case referred to dica Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Tyes 2 M No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, this within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Mann Death Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred Natural 5 Pending Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29c. License numbe 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 925 Bishool 31. Date filed (Month, Day, Year) State JUL 2 8 2011 Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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		State Registrar	(D	С	ertificate of	Death		eg. N2 ()		24118
Physicia Medic		1. Decedent's Name (First, Middle, Helen M. Ort	*				July 14,		Year	3. Time of Death 4:17 A M
Examin		4a. Facility Name (if not institution, Southern Mary)			4b. City, Town, Clinto	or Location of Death	1		y of Death ce Georg	æ's
Funeral Director		5. Social Security Number 579 32 8006		ge (In yrs. last birthda Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birth (Month, Day, April 13.			ace (State or Foreign
	ř	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location		TADELL 13,	1923		Od. Inside City Limits
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with the s 23a or ust be r	Funeral Director	10e. Street and Number 8908 Clayton	Lane		10f. Zip Code	20735	1	0g. Citizen of United		ry?
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	۾	11. Marital Status 1 ☐ Never Married 2 ☐ Marr XX Widowed 4 ☐ Divorced	ied 12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.		3. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 🔀 No	an, Mexican, Puerto	pecify Yes or No- po Rican, etc.)		ce - America ack, White, et y: Whit	tc.
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12 should sith and N 27 is marr trauma		19a. Informant's Name/Relationsh Kellie Rae Thorn		nter) 19b. Ma 259	ailing Address (Street 70 Timothy (and Number or Rui Court, Mecha	ral Route Number, (anicsville,	"MD" 2065	State, Zip Co	ode)
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permit. Pa Departme Importan any injury		4 □ Donation 5 □ Other (S) 21. Signature of Funeral Service Li	rensee		Veterans Cen 22. Name and Addre Ferry Road,			<u>Cheltenh</u> ome,Inc		ryland ld Alexandria
Physician/ Medical Examiner	niner	23a. Part 1. Enter the disease, or shock, or heart failure. List of immediate Cause (Final disease or condition resulting in death) Esqueritally list conditions, if any, leading to immediate cause. Enter Underlying	a. Due to (or as	e.	inter the mode of dyli				L 1	Approximate Interval Between
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To the Hospital or Attending Physician: The law requires that the death certificate is within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completed filled in by the funeral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🙀 No 9 ☐ Unknown		2 Fetal death 3	Ectopic pregnan	су			ate of delivery	'Y Day Year
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To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 to make the completed filled in by the funeral director.	al Certificate:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determin	not be 28e Place of Inju	ury - At home, farm, s c. (Specify)			28f. Location (Stre City or Town,		er or Rural R	loute Number,
he Hosp iin 24 hou he Fune ipleted fil	Medical	(Check 2 Medical Ex	Physician: To the best of caminer: On the basis of e Nurse Practioner: To the	examination and/or inv	estigation, in my opini	on, death occurred a	at the time, date and	place, and du	ue to the caus	se(s) and manner stated.
To t		29b. Signature and title of certifier			29c. Licens	e number	29	d. Date signe	d (Month, Da	ay, Year)
262		30. Name and address of person w	the completed cause of d	leath (Item 23a) (Type	Print)	E CEAN	FR W	4-UNDA	F.M	W. 22602
Stat Registra	C	31. Date filed (Month, Day, Year)	5 2011 32. Registra	ar's Signature	parted					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month July Physician/ Chrispen Frederick Preston 2011 2:40рм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Potomac Valley Nursing Home Rockville Montgomery Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 🛛 M 2 🗆 F Months Days 579-32-8161 Washington, DC **Director** May Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director Burtonsville. 1 Yes 2 X No Maryland Montgomery 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a U.S.A. 3304 Lyncrest Court 20866 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 X No Black, White, etc. ò þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 K No Specify: "natural", Specify: 3 X Widowed 4 Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Metro. Police Dept. Police Captain Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental + မ Archie Frederick Preston Mary Christine Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 3304 Lyncrest Court, Burtonsville, Maryland 20866 Michael F. Preston - Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 \overline{X} Burial 2 \square Cremation 3 \square Removal from State Mt. Carmel UMC Cem. 107/14/2011 4 ☐ Donation 5 ☐ Other (Specify) Sunshine, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home. medanellarnon 1232 111800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician Cardiopulmonary Arrest disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sepsis quentially list nundflur s if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Failure to Thrive Due to (or as a consequence of) resulting in death) Last burial physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) signed by the atte in the past 12 months? Month Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Cerebrovascular Accident 1 Tes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 X No Yes completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 2 X No 1 Yes ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 X Nursing Home 5 - Residence 6 - Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work?
1 Yes 2 No 1 X Natural ☐ Accident ☐ Suicide Investigation 6 Could not be within 24 hours after deat To the Funeral Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 \square Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of pertifier 29d. Date signed (Month, Day, Year) Calus in ess of person who completed cause of death (Item 23a) (Type, Print) 9901 Medical Center Drive, Rockville, Maryland 20850 Marichu Matas, M.D. 31. Date filed (Month, Day, Year)

State

Registrar

14 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Donald Joseph Pastorett, Sr. July 2011 9. 12:00 p^M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 209 W. Main Street Emmitsburg Frederick Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, 1 X M 2 - F Months Hours Director 215-42-4149 68 New York Apr Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Frederick Emmitsburg 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 209 W. Main Street 21727 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ★ Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white Completed Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Manufacturing Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas Pastorett Mary Alice Kaas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Pastorett, son 209 W. Main Street, Emmitsburg, MD 21727 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State 7/12/2011 Mountain View Cem. 4 ☐ Qonation 5 ☐ Other (Specify) Harney, MD ire Funeral Service Licensee 21. Signa 22. Name and Address of Facility Myers-Durboraw Funeral Home Emmitsburg, MD 21727 210 W Main St, 23a. Part 1. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List Interval Between Immediate Cause (Final et and Death Physician/ disease or condition resulting in death) ssin Medical to (or as a cor sequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and deelected for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 2 No 3 Probably 4 Unknown should peen Were autopsy findings available prior to completion of cause of 24a. Was an ours after death.

eral Director. After this certificate has filled in by the funeral director, page 2.8 death? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes Other: 2 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural work' 5 Pending 1 🗌 Yes 2 No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical axaminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check 3 Certifying To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) WJL 120018701 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CARROLL M.D 310 SETON AUE. EMMITSBURG,

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

32. Pegistrar's Signature

MD

21727

Physicia /Medic Examin

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial present Division or Vital Records, P.O. Box 68760, Sta Registr

1 - For State Registrar	State of Maryl	Ce	ertificate	of Death	Reg.		1 2412		
1. Decedent's Name (First, Middle, I	Karen	Miriam	RUBIN	Rosenbaum	2. Date of Death Month July 13,	Day Year	3. Time of Death 6:32 A M		
4a. Facility Name (If not institution, g		1503		Town, or Location of Dear		4c. County of Dea	ath		
5. Social Security Number 6 554-49-7913	Sex 7. Age (In)	rs. last birthday		1 Year If Under 24 Hrs Days Hours Min			ish ngtonyDa Tifornia		
Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or I	_ocation				10d. Inside City Limits		
Maryland Prince	e Georges	Col	lege I		10a	Citizen of What C	1 Tyes 2 No		
6100 Westchester	r Park Drive #	1503	101. 2.19	20740		Inited St	•		
11. Marital Status 1 □ Never Married 2 🕍 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1	n U.S. 13	Mas Deced	ent of Hispanic Origin? (sify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Am Black, Wh Specify:			
15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	Educatio	•							
17. Father's Name (First, Middle, La	•	100	cher	1	me (First, Middle, Maid	den Surname)	11		
	ick Rosenbaum	405 14-5	War Adda		endy Fay Mi		7:- 0 - 4-1		
John Wielgosz,	1 21	4108	B Culve	(Street and Number or Fi er Street, k	Kensington,	MD 208			
20a. Method of Disposition 1 X Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe	LAMBINOVAL HOLLI State	b. Place of Disposers, citive Miv		ne of ther place) 07/1		srael	r Town, State		
21. Signature of runeral service tro	MO	1008	Chenny	iskyssflebyew rroll St., N	Funeral Ho	me uton. DC	20012		
23a. Part Epier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic Breast Cancer Due to (or as a consequence of):									
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.									
Cause (Disease of Injury that initiated events resulting in death) Last C Due to (or as a consequence of):									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\frac{1}{2}\) Yes 2 \(\sigma \) No 9 \(\sigma \) Unknown \(\frac{1}{2}\) Unkn									
Part II. Other significant conditions	s contributing to death but not	resulting in the	underlying ca	ause given in Part I.	23e. Did tobac		to the cause of death? Probably 4 ☐Unknow		
					24a. Was an autopsy performac 1 Yes 2 ☑	prior to	autopsy findings availab completion of cause of s 2 \(\) No		
25. Was case referred to medical examiner?	Hospital:			Other	ath (Check only one)				
FEMALE: 23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death 3 Ectopic pregnancy Month Day									
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		at home, farm, s ecify)	street, factory	, office	28f. Location (Stree City or Town, S	t and Number or l State)	Rural Route Number,		
29a. Certifier 1 X Certifying (Check only one) 2 Medical Ex	Physician: To the best of my aminer: On the basis of exan and manner stated.	knowledge, de nination and/or	ath occurred investigation	at the time, date and place in my opinion, death occ	e, and due to the caus curred at the time, date	se(s) and manner a and place, and d	as stated. ue to the cause(s)		
29b. Signature and title of gertifier	S			License number D 0035045	Ju	Date signed (Mor			
30. Name and address of person wh Philip G. Hengum	, M.D., 18109	ltem 23a) (Type Prince	Phili	p Drive, #20	00, 01ney,	MD 2083	32		
31. Date filed (Month, Day, Year)	82. Registrar's Si	gnature da	R.D.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Kathleen Diane Reichert Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death AILegany WM. Regional Medical Center Cumberland 7. Age (In yrs. last birthday) **79** vrs Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 214-30-4241 Days 1 □ M 2 🛣 F Months Hours NOV. 144 Year 1931 Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location notified at Director 10d. Inside City Limits MD Allegany Westernport 28a-f 1 X Yes 2 No 10e. Street and Numb 10f. Zip Code 21562 ms 23a or must be ı Og. Citizen of What Country? United States 221 Miller Funeral ir than "natural", or items the Medical Examiner mu death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Page 1 and 2 should be filed within 72 hours after dea. Department of Health and Mental Hygene. Important: If fen 27 is marked other to other trainments. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give 2X No white 1 Yes 2 No Specify: Completed 3 X Widowed 4 □ Divorced Specify. Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) **Homemaker** 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Housework Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Kathleen Mary Hollister ၉ Richard Charles Borden ng Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Miller St, Westernport, Maryland 21562 19a. Informant's Name/Relationship (Type, Print) Saran Price/ daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Philos Cemetery 20c. Location - City or Town, State Westernport, Maryland 07/2^{Date} 2011 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Boal Funeral Home 111 Church St, Westernport, Maryland 21562 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to improve cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a densequence of Hospital or Attending Physician: The law requires that the death certificate be executed -tran and that initiated events resulting in death) Last Due to (or as a consequence of): physician a s the burial-t Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Month Pregnant at time of death Year 2 No the 9 Unknown Unknown as been signed by tl 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ eonchronic renal 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Premonia 24a. Was an has e 2 autopsy page performed? Yes 2 No this certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 Yes 2 No Other: ျပ Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural (Month, Day, Year) To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completed filled in by the fun 5 Pending Accident 1 🗌 Yes Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined building, etc. (Specify) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) SUDHEER SANKOTHU D 6973 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Sudheer Sanikommu, 12500 Willowbrook Road, Cumberland, MD 21502

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

JUL 19 2011

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ S. J. Rohrer, Jr. _A M 2011 July $4 \cdot 35$ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington Boonsboro Reeders Memorial Home Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Oct 21, 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday) Hours Director Maryland 217-28-5737 'Î932 78 Usual Residence of Decedent important; if item 27 is marked other than "natural", or items 23a or 28a-f show may injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 11015 Rosewood Drive 21740 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 XX Yes 2 \sum No 1951- Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married 1 X Yes If Yes, Give 1 ☐ Yes 2 🔀 No Specify: Completed 3 X Widowed 4 Divorced 1955 White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Economic Development State of Maryland Be should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Health and Mental tem 27 is marked c Daniel S.J. Rohrer, Sr. Margaret May Poffenberger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 David J. Rohrer / Son 20154 Beaver Creek Road Hagerstown, Maryland 21740 Baltimore, Department of Hea Important; If item 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) Rose Hill Cemetery 07/20/2011 Hagerstown, Maryland Signature of Funeral S 22. Name and Address of Facility Bast-Stauffer Funeral Home, PA 7606 Old National Pike Boonsboro, MD Part 1. Inter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. 23a, Part 1 Onset and Death Immediate Cause (Final EMAL Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examine VLMUNDAY TBROSCE YEMS Sequentially list conditions, it any, reading to immediate cause. Enter Underlying DEMENITA Cause (Disease or iinjury sate has been signed by the attending physician and page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 D Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy **Director:** After this certificate in by the funeral director, pag death? 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Tes 2 X No Other ၉ 1 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 2 Inpa 4 Wursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 1 \(\text{Yes} 2 🗌 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide within 24 hours after To the Funeral Direc City or Town, State) Medical **Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d, Date signed (Month, Day, Year) ile der 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JIN-10+1 ROAD RADIR HAGENS TOWN 1190 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death July 12. Day Robinson Thomas Α. 201 Jean 1:25 P M 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4918 Prince George's Wealding Way Oxon Hill 5. Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Virginia 1 XX XM 2 🗆 F Days Hours 261-82-5724 b9/702/1945 65 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 K XNo Maryland Prince George's Oxon Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4918 Wealding Way 20745 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Vietna 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married **Black** Year or Dates. Vietnam 1 Yes 2XXNo Specify: XX Widowed 4 Divorced 16a. Decedent's Usual Occupation Give kind of work done during most of working Inför解科印码resecurity Program 15. Decedent's Education Washington, Metropolitan Airport Authority (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Specialist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robinson James Clara Rosa Debreux 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shean Robinson 9246 McCarty Road Lorton, Virginia 20a Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Kalas Crematory 1 Burial 2 X Cremation 3 Removal from State 7/20/2011 Edgewater, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home PA 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death RESPIRATORY FAILURE Due to (or as a consequence of): CONGESTIVE HEART FAILURE Due to (or as a consequence of) HYPERTENSION Due to (or as a consequence of) CORONARY ARTERY DISEASE

Other:

1 Yes 2 No

my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated

amination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

28c. Injury at

29c. License number D 006233

3 🗆 Certifying Nurse Fractione. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

4 ☐ Nursing Home 5XXResidence 6 ☐ Other (Specify)

28d. Describe how injury occurred

20895

28f. Location (Street and Number or Rural Route Number, City or Town, State)

07/14/2011

Day

2 🗌 No

Year

Physician/ Medical Examine

attending physician and

signed by t d be detach

Jas

this certificate

Physician/

Medical

Examiner

Funeral

Director

items 23a or 28a-f show ner must be notified at

er than "natural", or iter the Medical Examiner

other traumatic event,

"natural",

al Hygiene.

t. Page 1 and 2 should be filed rtment of Health and Mental Hi rtant: If item 27 is marked otl

permit. Page 1 and Department of I Important: If ite any injury or ot

Director

Funeral

Completed by

Be

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should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Examine Physician/Medical þ Completed Be 잍 Certificate:

Medical

examiner?

27. Manner of Death

1 X XNatural

Accident

Suicide

4 Homicide

29a. Certifier

(Check

only one)

29b. Signature and titl

2 No

5 Pending

Investigation

determined

Eertifying Physician: To the best of

Medical Examiner: On the b

6 Could not be

Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Live Birth 2 Pregnant at time of death 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 \square Yes 2 X No 3 \square Probably 4 \square Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed 1 Tes Yes 2x x No 25. Was case referred to medical 26. Place of Death (Check only one)

1 Inpatient 2 ER/Outpatient 3 IDOA

28e. Place of Injury - At home, farm, street, factory, office

etc. (Specify)

28b. Time of

injury

10+ State Registrar

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nan Wang MD10810 Connecticut Avenue Kensington, MD 31. Date filed (Month, Day, Year)

28a. Date of injury (Month, Day, Year)

building,

Hospital:

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2105
Amend Item 3 per med cert G918 8/3/11 dk
State of Maryland / Department of Health and Mental Hygiene 1 = For State Registrar Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Vea **Physician** 0 7 06 2011 21:05 P M tan race /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner STIC Same Nursing 10 Year If Under 24 Hrs. 8. Date of Birth

Pavs Hours Min. (Month, Day, Year, . Age (In yrs. last birthday If Under Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex **Funeral** Days Hours Months 1 □ M 2 1 F 215-26-251 Yrs Director MD Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h. County ns 23a or 28a-f show must be notified at 1⊈Yes 2 No Director MD Wicomico Fruitland 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 207 Pine Street 21826 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. item 27 is marked other than "natural", or items other traumatic event, the Medical Examiner m 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 **X**No African-Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify Specify: Completed by 3 ☐ Widowed 4 X Divorced American 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8 Housekeeper Medical Facility and Mental Hygic is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Golden Dashiell 2 Katie Waters 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 & Department of Health ar Important: If item 27 is any injury or other trau Rhoda Turner/daughter P. O. Box 4393, Salisbury, MD 21803 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Green Acres Mem Park 07/09/2011 Salisbury, MD 21. Signature of Frail Service Licenses Lewis N. Watson Funeral Home, PA

1618 West Rd., Salisbury, MD 21801

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Immediate Cause (Fine) 22. Name and Address of Facility Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CARRINA **Physician** mise /Medical Due to (or as a consequence of) Examiner ROWARI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as attending IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ę in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Vear 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ pe LING 1 Yes 2 No 3 Probably 4 Unknown funeral director, page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an certificate has autopsy 2 No 1□ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To After this 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident hours after death the 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29b. Signature and title of certified in 30. Name and address of person who completed cause of death (Item 23a) (Type, Print 2 trar's Signature 31. Date filed (Month, Day,, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Dea 5:10 A JW7 12, Da2011 Year Physician/ Saul STURMAN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery **Examiner** Rockville 14431 Traville Gardens Circle #216 If Under 1 Year If Under 24 Hrs. 8. Date of Birt Months Days Hours Min. Ocheonth, Day Birthplace (State or Foreign Country) New York 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Oc/Month, 27, Year 1923 Months 87 057-18-7116 **Director** Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10b. County 10c. City, Town or Location 10a. State er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at filed within 72 hours after death with the Maryland Director 1 🗆 Yes 2 🕅 No Rockville Maryland Montgomery 10g. Citizen of What Country?
United States 10f. Zip Code 10e, Street and Number 20850 Funeral 14431 Traville Gardens Circle #216 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 V Yes 2 No
If Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 🔀 No Specify: Specify: 3 Widowed 4 Divorced Year or Dates. WW 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Danker Furniture Salesman other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname)
Bella Turshwell permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event one. 17. Father's Name (First, Middle, Last) ပ Joseph Sturman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10817 Tuckahoe Way, N. Potomac, MD Steven Dorne, Son-In-Law 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Olney, MD Judean Memorial Gardens 07/14/11 4 ☐ Donation 5 ☐ Other (Specify) Toroninsky Hebrew Funeral Home 21. Signature of Fune of Revice Licensee 20012 254 Carroll St., NW, Washington, DC 23a. Parl 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shown or heart failure. List only one cause on each line. Approximate Interval Between Y Conset and Death Congestive Heart Failure Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Years <u>Coronary Heart Disease</u> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner been signed by the attending physician and should be detached for use as the burier pensit Cause (Disease or iinjury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months?

1 Yes 2 No Month Other (specify) Pregnant at time of death g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Diabetes Mellitus 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 2 performed? 1 Yes 2 No this certificate 25. Was case referred to medical 26. Place of Death (Check only one) the funeral director, Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 2 XNO 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After 1 work? 1 Natural iniury 5 Pending 2 🗆 No Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signatu and title of certifie 29d. Date signed (Month, Day, Year) 6010 Inne 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ill Teets-Salb	1- For State	Maryland / Department Certificate		Hygiene Reg. N	. 2011	24127
Physician/	1. Decedent's Name (First, Middle,Last)		-	Date of Death Month Day		3. Time of Death 0602 hrs
Medical Examiner	JILL ANN SALB 4a. Facility Name (if not institution, give si	reet and number)	4b. City, Town, or Location of Dea	July 13, 2011	4c. County of Death	
	Baltimore Washington Medic		Glen Burnie		Anne Arundel	
Funeral Director	5. Social Security Number 6. Sex 219-84-4048 1 M	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24H Months Days Hours M 'rs.	_	M/DD/YYYY) 9. Birth Foreign Cour	
v any	Usual Residence of Decedent 10a. Stete 10b. County	10c. City, Town or Loc				10d. Inside City Limits 1 X Yes 2 No
Maryland 28a-f show 1 at once.	MD Anne Aru	indel Pasaden	a 10f. Zip Code	110g C	itizen of What Count	
the Maryland Sa or 28a-f sh otified at once	7729 Jones Dri	.ve	21122		.s.	
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other transmatic event, the Medical Tax sincr must be notified at once or other transmatic event, the Medical Tax sincr must be notified at once To Be Completed by Funeral Director	3 Widowed 4 Divorced in	Armed Forces? Yes 2 No Yes, Give Year	Was Decedent of Hispanic Origin? (f Yes, specify Cuban, Mexican, Puer Yes 2 X No specify:		14. Race - America White, etc. Specify: Whit	
"natural"	45 Decedent's Education (Considerable	College (1-4 or 5+)	ent's Usual Occupation (Give kind o most of working life. DO NOT use re	etired)	. Kind of Business/Inc Childrens	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu injury or other transmatic event, the Medical In-	17. Father's Name (First, Middle, Last)	Day	Care Provider 18.Mother's Nar	ne (First, Middle, Maidd Friend I	en Surname)	SELVICE
Baltimore, MD 21215-003 permit. Pages 1 and 2 should be filed withi Department of Health and Mental Hygiene. Important: If item 27 is marked other ti injury or other transmatic event, the Mod	Steven Bowen 19a. Informant's Name/Relationship (Type	e, Print) 19b. Mai	ing Address (Street and Number o	r Rural Route Number,	City or Town, State,	Zip Code)
MD 2 sh salth an 27 i	Irene Thomas 20a, Method of Disposition	20b. Place of Disp	Richfield La	Date 20	c. Location - City or T	own, State
Imore Pages 1 is nent of H	1 XXBurial 2 Cremation 3 4 Donation 5 Other Specify:	Terra Al	ta Cemetery 7	/16/2011		lta, WV
Balt permit. Departr Import	21 Signature of Funeral Service Licenses	1/1/1/100)	Name and Address of Facility Arthur H. Wright 105 Highland Ave.	, Terra Al	.ta, wv	26764
Physician /Medical	23a. Part I. Enter the dise so, or complications. List only one cause on each Immediate Cause (Final disease a. Miles	tions that caused the death. Do not ente	r the mode of dying, such as cardiac	or respiratory arrest, s	shock, or heart	Approximate Interval Between Onset and Death
Examiner	or condition resulting in death)	e to (or as a consequence of):				
red 1 Insit Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	e to (or as a consequence of):				
uted or ransit	events resulting in death) Last Du	e to (or as a consequence of):				
to be executed burial - transit	UNPENDED	AMENDED				
Division of Vital Records, P.O. Box 6876(To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy- completely filled in by the funeral director, page 2 should be detached for use as the b ledical Certification: To Be Completed by Physician/Me		23c. If yes, outcome of pregnancy 1 Live birth 2 4 Pregnant at time of death 5 Unknown	Fetal death 3 Ectopic preg		23d. Date of delivery Month Da	ay Year
O. By at the de stached f		ontributing to death but not resulting in th	e underlying cause given in Part I.		co use contribute to the	_
ds, P.C equires that een signed vuld be deta				24a. Was an		ppsy findings available
Records, The law requires froate has been sig yage 2 should be				autopsy performed	? death?	mpletion of cause of
icentific rector, j	25. Was case referred to medical examiner?	pital: 1	26.Place of Death (Chec		idence 6 Other:	
n of Vi ding Physi After this funeral di	1 Yes 2 No	28a. Date of Injury Jul 13, 2011 28b. Time of O506 hrs		28d. Describe how Subject stabbe	injury occurred	
Division of Vital Records, P.O. spital or Attending Physician: The law requires that th hours after death. neral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detach. Certification: To Be Completed by P	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, s (Specify) Single Family Home	reet, factory, office building, etc.	28f. Location (Stree or Town, State 7729 Jones Drive		al Route Number, City
Divis To the Hospital or Awithin 24 hours after To the Funeral Dire Completely filled in be		: To the best of my knowledge, death oc n the basis of examination and/or investi	curred at the time, date and place, a	nd due to the cause(s)	and manner as state	d. cause(s)
To the Ho within 24 To the Fu Complete!	29b. Signature and title of certifier	nd manner stated.	29c. License number O.C.M.E.	29	d. Date signed (Moni	
	30. Name and address of person who cor		00 W. Baltimore Street, Baltimore			
State		Loo Businessa Signature		- IVIO Z IZZ		
Registra		production of the second	K)		<u></u>	
DHMH 17 Rev 1/2001		OCME ORIGIN	IAL			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year 46 A M Month P DUSEPH Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death George Hospital 8. Date of Birth (Month, Day, If Under_1 Year 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under Social Security Number **Funeral** 1 M 2 - F Months Days Min Hours 36 9614 NIARY Director -1938 Usual Residence of Decedent 28a-f shov 10b. County filed within 72 hours after death with the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 🗗 Yes 2 🗆 No Marzyland Waldort 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ıral", or items 23a or Examiner must be Funeral Buwker Hzll 20603 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ò 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify "natural", Specify: 3 Widowed 4 Divorced Completed Black the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) LWSpector permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Nathanie Shirriel Catherine Proctois 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirriel Rd laldorf Bunker Hall 20603 URIS Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State Date 1 🕻 Burial 2 ☐ Cremation 3 ☐ Removal from State MAR 7-16-11 Donation 5 Other (Specify) Signature of Auneral Service License Name and Address of Facility MI 20608 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ ororom disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) -transit To the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last burialattending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 2 No been signed by the should be detached g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performe To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 Yes 2 XNo 1 Yes 2 X No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA Certificate: To 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred atural work? 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D46478 -11-11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) clinton mp 20735 Surratts Rel an 7501 th, Day, Year) 31. Date filed (Month egistrar's Signatu State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Dav Year 3 : I OAM 201 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death exington rake If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 02/25/1924 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕱 F Hours Min **Director** 219-16-1173 87 Maryland Usual Residence of Decedent shov or 28a-f shov se notified at 10b. County with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Marvland St. Mary's California 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 23752 St. Clair Road 20619 USA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, ð 1 Never Married 2 Married ☐ Yes Yes, Give Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Completed 3 X Widowed 4 Divorced Specify: White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) Food Service Navy Exchange permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ James Osborne Tucker Lillian Ruth Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Francis St. Clair/Son 23752 St. Clair Road, California, MD 20619 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. John's Catholic 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 07/21/2011 Hollywood, MD 4 Donation 5 Other (Specify) Sunature of Funeral Service Lice Mattingley-Gardiner Funeral Home, P. P.O. Box 270, Leonardtown, MD 20650 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ disease or condition resulting in death) Medical Due to pr Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and deetached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Year Month Day Pregnant at time of death 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perforn 1 Yes 2 No 1 Yes 25. Was case referred to medical funeral director, æ 26. Place of Death (Check only one) examiner? 1 🗆 Yes Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) Director; After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending work 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined within 24 hours after To the Funeral Direc City or Town, State) Medical 1 Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 29b. Signatu 29d. Date signed (Month, Day, Year) 0026262 30. Name and address of persor ompleted cause of death (Item 23a) (Type, Print) Samue1 J. Kleiman M.D11711 Livingston Rd., Fort Washington, MD 20744 31. Date filed (Month, Day, Year) Registrar's Signat State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryland / Department / Department / Department / Department / Department / Departm	artment of H <i>rtificate of L</i>			iene _{eg. N} 2011	24130
ı			1. Decedent's Name (First, Middle, Last)		2.	Date of Deat	h Day Year	3. Time of Death
	Physici: /Medic		Mae Harwell Sides		J	-	15, 2011	2:00 PM M
-	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or	Location of Death		4c. County of Dea	th
أبر			Solomons Nursing Center 5. Social Security Number 6. Sex _ 7. Age (In yrs. last birthday)	Solomo If Under 1 Year	If Under 24 Hrs. 8	Date of Birth	Calvert	thplace (State or Foreign
	Funeral Director		257-28-3445 1□ M 2	Months Days	Hours Min.	(Month, Day, uly 23	, 1923 Ge	orgia
	land bw		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	cation				10d. Inside City Limits
	Mary I-f sho fied a	tor	Maryland St. Mary's Lexingto	on Park				1 □Yes 🛣 No
	h the or 28g	Directo	10e. Street and Number	10f. Zip Code		1	0g. Citizen of What Co	ountry?
	23a c		21529 Lynn Drive	20653			U.S.A.	
	tems term	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 1 □ Never Married 2 □ Married 1 □ Yes 2 ↑ No	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Specif an, Mexican, Puerto Ric	fy Yes or No- can, etc.)	14. Race - Ame Black, Whit	
36	thin 72 hours after death with the Maryland e. an "natural", or items 23a or 28a-f show Maricel Exteniner must be notified at	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 22 ☐ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 □ Yes 2 📉 No	Specify:		Specify: Wh	ite
215-0036	2 houra		15 Decedent's Education 16a, Dece	dent's Usual Occup	ation	T	16b. Kind of Business	
212	hin 7% e. an "n	Completed	(Specify only highest grade completed) (Give Elementary/Secondary (0-12) College (1-4or 5+)	kind of work done on DO NOT use retired	during most of working d)			
	문도로에	Con		e Maker			Own Hom	e
Maryland 21	be filed ntal Hygi od other event, t	Be	17. Father's Name (First, Middle, Last)		18. Mother's Name (F			
<u>₹</u>	nould d Mer narke natic	2	Idus Key Harwell	A.I.I (Otro- et	Mattie and Number or Rural F	India	Smith	Zin Cada)
<u>a</u>	d2st Ith an 17 is r traur		· · · · · · · · · · · · · · · · · · ·		. St. Mary			
	f Hear f Hear tem 2		James Lee Sides / Son P.0 20a. Method of Disposition 20b. Place of Disposition cemetery, crer.				20c. Location - City or	
altimore,	permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygie Important; If item 27 is marked other t any Injury or other traumatic event, the		I M Burial 2 Li Cremation 3 Li Removal from State		ns. 7-20-	2011	Great Mi	11a MD
a	mit. I partm porta / Inju	Į. Ji	DVCIGICO		ss of Facility Brin			
מ	an E o		Edward N. Brinsfield, Jr. M00052 22	2955 Holl	ywood Road	, Leona	ardtown, M	D 20650
			23a. Part 1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.	er the mode of dyin	ng, such as cardiac or r	espiratory arr	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition a. Attended to the condition a. Attended to the condition a.	4 C Can	he vacu	lar d	usease	Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):					
	- Adminior	Į.	Sequentially list conditions, b. Due to (or as a consequence of).					
	uted I nsit	Examiner	cause. Enter Underlying Cause (Disease or injury					
Ĵ,	exectin and ial-tra	Exa	that initiated events c c Due to (or as a consequence of):					
09/89	ficate be executed g physician and s the burial-transit	edical	d					
_		Med	IF FEMALE:			0.00		
go	death certific e attending p d for use as 1	ian/l	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 D	Ectopic pregnanc	y		23d. Date of de Month	elivery Day Year
	0 0 0	Physician/M	1 ☐ Yes 2 ☑ No 9 ☐ Unknown 5 ☐	Other (specify) _				,
Ţ.	that the dened by the a		Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause giv	en in Part I.	23e. Did to	bacco use contribute	to the cause of death?
Vital Records	w requires that the s been signed by th should be detache	d by	Lung Tumoy			1 □ Ye	es 2□No 3□F	Probably 4 Unknown
ပ္ပ		Completed	Atrial Ribrillation			24a. Was a	n 24b. Were a	autopsy findings available
ř	The la	mo	Encl Stage Dementia			autops perfori	med? death?	completion of cause of s 2 \Bo
<u>ra</u>	sician: The law certificate has k irector, page 2 sl	BeC	25. Was case referred to medical examiner?		26. Place of Death (
01	hysic this ca tl dire	၉	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien		4 Mursing Home		ence 6 □Other (Sp	ecify)
	ding Phys n. After this funeral dir	ion:	27. Manner of Death 1 Matural 5 Pending (Month, Day, Year) 28a. Date of Injury (Month, Day, Year) Injury	Worl		d. Describe he	ow injury occurred	
<u>s</u>	r Attender death rector:	icat	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, str		Yes 2 □ No	f Location /S	treet and Number or F	Rural Route Number
UIVISION	l or A after Direc	Certification:	4 Homicide determined 256. Place of Injury - At Northe, farm, str	eet, lactory, office	20	City or Town		lurar riodic rvamoor,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, I		29a. Certifier Certifying Physician: To the best of my knowledge, deat					
	he Ho In 24 he Fu pletel	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	vestigation, in my c	opinion, death occurred	f at the time, c	date and place, and du	ue to the cause(s)
	To the within 3 To the comple	M	29b. Signature and title of certifier	29c. Licens		2	29d. Date signed (Mor	
			Lyan.e. Surana.		50653		7-15-	2011
	me		30. Name and address of person who completed cause of death (Item 23a) (Type, 5851. Deale Churchton	Print) GY1	an .e.	SIJRI	ANA	to street account
S.	Sta	to	31. Date filed (Month, Day, Year) 32. Aegistrar's Signature	Koad	De a)	e m	1D 26	0757
	Registr		JUL 19 2011	ale				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State	tate of Maryland				Mental Hyg	giene		21.121
			Registrar 1. Decedent's Name (First, Middle, Last)		Cer	tificate of L	Death	2. Date of Dea	Reg. Na. U		24131
man	Physicia Medic	cal	Sophia J. Slay					Month	11 Day 20	Year	3. Time of Death 04 = 25M
	Examir	ner	4a. Facility Name (if not institution, give stree	edical Cista		4b. City, Town, or	Location of Dear	th /	4c. County	of Death	,
	Funeral Director		5. Social Security Number 6. Sex	2 🕱 F 96	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Ars Hours Min	U. Date of Difti	1	9. Birth	place (State or Foreign try) York
	nd now at	١	Usual Residence of Decedent 10a. State 10b. County	10c City	Town or Loc	cation					0d. Inside City Limits
	farylar Sa-f sl	Director	Maryland Wicomico		lisbur						1 ☐ Yes 2 🌠 No
	a or 2	٥	10e. Street and Number			10f. Zip Code			10g. Citizen of V	Vhat Cour	ntry?
	th with ms 23 must	Funeral	6270 Diamondback Di			2180			USA		
036	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Completed by Fu	1 Never Married 2 Married	Was Decedent Ever in U.S. Armed Forces? I Yes 2 X No f Yes, Give ∕ear or Dates.	l1	Vas Decedent of Hi Yes, specify Cuba	n, Mexican, Puer	pecify Yes or No- to Rican, etc.)		e - Americ k, White, e Wh	etc.
5-0	2 hour	plet	15. Decedent's Educat (Specify only highest grade co			ent's Usual Occupa		rking	16b. Kind of Bu	usiness Inc	dustry
121	within 7 giene. ler than t, the Me	mo m		College (1-4 or 5+)	life. DO	NOT use retired) d Bookkee		nang	Banking	4	
1d 2	filed within 72 al Hygiene. d other than '	B	17. Father's Name (First, Middle, Last)	2	nea	a bookke		me (First, Middle, M			
ylar	ld be f Menta arked atic ev	욘	Benjamin Albert War	nshuis			Hattie	Johanna !	Tewinkle	è	
	and 2 should be file Health and Mental I tem 27 is marked o other traumatic eve		19a. Informant's Name/Relationship (Type, F Mary S. Lundberg/da		19b. Mailin 627	g Address (Street a O Diamono	and Number or Ridback Dr	ıral Route Number, •, Salist	City or Town, S OURY, MI	tate, Zip C 218	Code) O1
	permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other once.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Rem 4 □ Donation 5 □ Other (Specify)	oval from State ce.	metery, crem	sition (Name of patory or other place Cemetery	· .	Date 1/2011	20c. Location -	-	
Balti	permit. Page Department or Important: If any injury or once.		21. Signature of Fureral Service Licensee	Bland							sociation 4
	Physician/ Medical Examiner		23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one can immediate Cause (Final disease or condition resulting in death)	ons that caused the death, use on each line. ASCLOD Due to (or as a conseque		r the mode of dying	g, such as cardiad	c or respiratory arre	est,		Approximate Interval Between Onset and Death
	cate be executed physician and sthe burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		İ						
09	ite be hysicii he bu	dica	d							\perp	
Division of Vital Records, P.O. Box 68760	to the hospital or Attending Physicians. The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	by Physician/Me	in the past 12 months?	f yes, outcome of pregnand Live Birth 2 Fetal Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)	У		23d. Dat Mor	e of delive	ery Day Year
, P.O	es that the signed by be detact	d by Pr	Part II. Other significant conditions contribu	iting to death but not resul	Iting in the ur	nderlying cause give	en in Part I.				e cause of death?
ords.	requir been s should	letec						-			
Reco	: The law icate has r, page 2 :	Completed						24a. Was ar autops perform 1 Yes	ned? d	rior to cor eath?	osy findings available inpletion of cause of
/ital	Sician certif irector	э Ве	25. Was case referred to medical examiner? 1 Yes 2 No	tal:		0.11	ce of Death (Che				
_ 	g Phy erthis nerald	te: To	27. Manner of Death 2	1 Inpatient 2 E	28b. Time of	28c. Injury	4 □ Nursing F at	lome 5 Reside			
0	eath. or: Aft he fur	ficat	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	injury	M 1 🗆 v	Yes 2 No				
Divisi	ital or Attures after de ral Directo led in by t	al Certificate:	3 ☐ Suicide 6 ☐ Could not be determined	Be. Place of Injury - At hom building, etc. (Specify)	ne, farm, stre	et, factory, office		28f. Location (Sti City or Town		r or Rural	Route Number,
:	the Hosp nin 24 hou the Funer	Medical	29a. Certifier (Check 2 Medical Examiner: Conly one) 3 Certifying Nurse Pra	To the best of my knowled in the basis of examination a ctioner: To the best of my	and/or investi	gation in my opinion	death occurred	at the time date and	d place and due	to the call	ce(c) and manner stated
			29b. Signature and title of certifier			29c. License	199.		9d. Date signed : 7 12 1	1	
	UTE		30. Name and address of person who comple	eted cause of death (Item 2	3a) (Type, Pr	int) 5140 R	EDF.	SA LISBUL	Y, MD,	218	504.
	Stat Registra	•	31. Date filed (Month, Day, Year)	32. Har istrar's Signatur	re A	(4)					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Margaret Snyder 0 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Salisbury Rehabilitation + Nursing C vicomico 8. Date of Birth g. Birthplace (State or Foreign 7. Age (In yrs. last bi **Funeral** Months Hours Min Pennsylvania 188-07-2661 0572171916 Director Usual Residence of Decedent 28a-f show 10a. State notified at 10c. City. Town or Location Director 10d. Inside City Limits Maryland Wicomico Salisbury 1 XX Yes 2 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Examiner must be items 23a Funeral 21804 200 Civic Ave. USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Was Decedon 2 Armed Forces? 1 ☐ Yes 2 🗶 No Black, White, etc. "natural", or þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White 3 🛛 Widowed 4 🗌 Divorced Specify: Completed the Medical 15. Decedent's Education (Specify only highest grade completed) Baltimore, Maryland 21215-16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Domestic is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ethel McVicker Alex Wilson traumatic 19a. Informant's Name/Relationship (Type, Print)
Kathy Gray/daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 1015 Emmanuel Church Rd., Huntingtown, MD 20639 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Juniata Memorial Park 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State 7/15/2011 Lewistown, PA 4 Donation 5 Other (Specify) . Signature of Furferal Service Licenses Holloway Funeral Home Professional Association Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final .₽hysician/ disease or condition ear Medical resulting in death) Due to irr as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and the attending physician and hed for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year 2 No ate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 10 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an after death.

Director: After this certificate has performed' 1 Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 □H\0 Other မ 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred □ Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation completed filled in by the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier crtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MID State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number City, Town, or Location of Death County of Death Examiner Kent If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Min Yrs Virginia 64 Director shov 10a. State 10b, County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director Galena 1 Yes 2 X No MD Kent 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral U.S.A. 32060 Shorewood Rd. 21635 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) death 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☑ Yes 2 ☐ No 1969 Black, White, etc. 1 Never Married 2 X Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: 3 Divorced 4 Divorced -1971Year or Dates. Department of Health and Mental Hygiene Important; If item 27 is marked other than "natu any injury or other traumatic event, the Medical 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Automobile Elementary/Seconday (0-12) Manufacturer Electrician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Sara Elizabeth Baylor Whitmel Francis Sanderson, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 32060 Shorewood Rd. Galena, MD. 21635 Peggy S. Sanderson (wife) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 □ Cremation 3 □ Removal from State remetery, crematory or other place)
Fairview Lawn Cemetery 7/28/11 Onancock, VA. 4 Donation 5 Other (Specify) Galena Funeral Home of Stephen L. Schaech M00510 118 West Cross St. Galena, MD. 21635 Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or consequence of) **Examiner** Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 X No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an cate has t autopsy 1 Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, I 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Tes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident 3 Suicide 4 Homicide Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of D5605

Registrar
DHMH 17 Rev 7/2009

En

32. Registrar's Signature

120 Speer Rd.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Patrick Shanahan, M.D.

31. Date filed (Month, Day, Year)

282011

Chestertown, MD. 21620

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 24134 Reg. N2 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month July 16, 2011 Magdeline 6:35 p M Edna Thompson Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Calvert Solomons Nursing Center Solomons If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 X F Director 212-88-4237 88 04/17/1923 Maryland Usual Residence of Decedent or 28a-f show notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director St. Mary's Mechanicsville 1 Yes 2 X No Maryland 5 10e. Street and Numbe 10f. Zip Code ms 23a or must be n 10a. Citizen of What Country? Funeral 39393 Harpers Corner Road 20659 USA ral", or items 2 | Examiner mus 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 ☐ Yes 2 🛣 No If Yes, Give 1 Never Married 2 Married 3altimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify: Item 27 is marked other than "natural", other traumatic event, the Medical Exar 3 X Widowed 4 Divorced Specify Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 8 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed Department of Health and Mental H Important: If item 27 is marked ott any injury or other traumatic even 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Zachariah Pilkerton Lillian Hill Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melissa L. Lewis/Daughter 39393 Harpers Corner Rd., Mechanicsville, MD 20659 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Charles Memorial Grd 07/22/2011 Leonardtown, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen ²² Martingley-Gardiner Funeral Home, P P.O. Box 270, Leonardtown, MD 20650 23a. Part/1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line cadoni Immediate Cause (Final Onset and Death erebro Physician/ ascul disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Due to or as a consequence of Examir Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury and -trans that initiated events resulting in death) Last Due to (or as a consequence of) physician a the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 been signed by the attending I should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Day Year Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ALZHEIMERI EMENTIA 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe certificate 2 🗆 No Yes 2 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 PN0 1 🗌 Yes ဂ္ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Min of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending work? within 24 hours after death.

To the Funeral Director: A completed filled in by the fi 1 🗌 Yes 2 No Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29h Signature and title of certifier 29c. License number 0001942

DHMH 17 Rev 7/2009

State Registrar ANWAR MU 31. Date filed (Month, Day, Year) .130 DIOSP ROAD. PRINCE FREDERICK MD 20678

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

MUNSHI.MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 7:14 pm Erin Ann Turk W Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Medica nari If Under 9. Birthplace (State or Foreign Country) Mississippi 7. Age (In vrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth Social Security Number **Funeral** (Month, Day, Months Days Hours Min. 1 □ M 2 🖫 F 425-58-4448 Yrs **Director** 1934 Oct. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified Maryland Charles Waldorf 1 Yes 2 No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? 23a Funeral 61 Keepsake Place 20602 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ò Completed by 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 X Divorced permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Civil Servant Federal Government Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Gerald Burdine Ann Judge 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Turk/Son 61 Keepsake Place, Waldorf, MD 20602 timore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🗆 Burial 2 🛚 Cremation 3 🗀 Removal from State July 19, Brinsfield-Echols Crem. Charlotte Hall, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Brinsfield-Echols F.H., P.A., Si mature of Funeral Service Licenses MO0817 30195 Three Notch Rd., Charlotte Hall, MD 20622 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CHNCER Lung disease or condition Medical resulting in death) Due to (or as consequence of): Examiner META ITATTO if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events southing in death). Examine Due to (or as a consequence of) The law requires that the death certificate be executed the burial-transit signed by the attending physician and Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? certificate 1 Ves 2 No or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 \sum Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director. After this completed filled in by the funeral director. 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 1 Natural 5 \square Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year)

State Registrar gistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hidrary CAINEI, M-2 5 (1971)

31. Date filed (Month, Day, Year)

17230

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ J_{uly}^{Month} Grace Urie Α. 12 2011 12:05 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Silver Spring Bedford Court Nursing Home Montgomery Social Security Numbe 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country)
 MD **Funeral** Feb. 18, 1 🗆 M 2 🕱 F Months Hours Min. Year 933 Director 78 212-30**-**8756 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 10d. Inside City Limits 1 Yes 2 X No MDMontgomery Silver Spring 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? must be Funeral 15503 Prince Frederick Way 20906 USA ral", or items 2 Examiner mus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 Yes 2 No Specify. Specify: White 'natural", 3 Widowed 4 Divorced Completed the Medical Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) alth and Mental Hygiene. 27 is marked other than er traumatic event, the Me than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Executive Secretary State Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည George Edgar O'Donnell Grace Elizabeth Leitch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trac William A. Urie/Husband 15503 Prince Frederick Way, Silver Spring, MD 20906 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 A Burial 2 Cremation 3 Removal from State July Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) $\bar{2}01\bar{1}$ Silver Spring, MD 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 Approximate Interval Between Onset and Death 2 vrs 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Carcinoma of Larynx yrs Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): as the burialthe attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months?
1 ☐ Yes 2 🗷 No Month Day Year signed by the at d be detached for Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1^X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' Yes 2 XIN 1 🔲 Yes 25. Was case referred to medical ompleted filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 🛣 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 🛮 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: within 24 hours after death.

To the Funeral Director: After 28d. Describe how injury occurred 1 Natural
2 Accident work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

10

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Burt I. Feldman, MD

JUL 14 2011

D23958

3305 N. Leisure World Blvd., Silver Spring, MD 20906

July 13, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 for State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 15, Day 2011 Physician/ July Michael Patton Warren, Sr. 4:35 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Mary's Hospital St. Mary's Leonardtown If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F Months Days Hours Min. (Month, Day, Year) 11/14/1946 California 64 Director 215-46-3594 Usual Residence of Decedent 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits with the Maryland than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Yes 2 X No Maryland St. Mary's Leonardtown 10e. Street and Number 10f, Zip Code 10g, Citizen of What Country? 23010 B Newtown Neck Road 20650 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black. White, etc. Completed by 1 Never Married 2 Married ☐ Yes 2 🗷 No 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Fence Company Salesman Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishers is marked o Kenneth Charles Warren Alice Elizabeth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is Bernadette M. Warren Wife 43112 Coles Dr. Hollywood, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Metropolitan injury or 1

Burial 2

Cremation 3

Removal from State 7/18/2011 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) Crematory 21. Simure of Funeral Service Lice 22 Name and Address of Facility
Mattingley—Gardiner Funeral Home, P.A.
P.O. Box 270 Leonardtown, MD 20650 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between nse and pearlings Immediate Cause (Final Physician/ disease or condition resulting in death) Medical ue to (or as a consequence of) **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): HECIDENT EREBROVASCULAR that initiated events resulting in death) Last Physician/Medical RTENSION IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 1 ☐ Yes 2 💢 No Other: မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate; 28d. Describe how injury occurred Hospital or Attending 1 A Natural
2 Accident
3 Suicide
4 Homicide (Month, Day, Year) injury 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State) 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) LOU ma 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
ATRICIA GURW, MI ST MARY'S (HOS/17 LEONARDTOWN, MARYLAND 20650 ST MARY'S HOSPITAL 3 pme Registrar's Signatu State

DHMH 17 Rev 7/2009

Registrar

Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 20 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month :18 Linda Kay Wilhide Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Meritus Medical Center Hagerstown Washington If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) ulv 18,194] 1 □ M 2 🛛 F Months Hours Country) Yrs **Director** 220-40-037] Maryland Usual Residence of Decedent show at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland **Funeral Director** must be notified 28a-f 1 ☐ Yes 2X No Maryland Washington Sharpsburg 20 10f. Zip Code 10g. Citizen of What Country? 23a 2809 Harpers Ferry Rd. 21782 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. ?7 is marked other than "natural", or iter traumatic event, the Medical Examiner Armed Force by 1 Never Married 2XXMarried 1 ☐ Yes 2XXNo filed within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2XXNo Specify: Specify: 3 Divorced 4 Divorced Completed Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Housewife Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental F ျ Oscar Leo Otzelberger Daisy Arbutus Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 Joseph C. Wilhide, Jr.-Husband 2809 Harpers Ferry Rd. Sharpsburg, Maryland 21782 permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from cemetery, crematory or other place) 4 Denation 5 Other (Specify) Samples Manor Cemetery July 20,2011 Sharpsburg, Maryland ture of Fyneral Service Sporne Augeradiv Home, P.A. 425 S. Conococheague St.Williamsport,MD 21795 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition month Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or burial-transit and Due to (or as a consequence of resulting in death) Last attending physician for use as the buria Physician/Medical law requires that the death certificate be Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery ō in the past 12 months? Month Day Year 1 Yes 2 No 9 Unknown signed by the a 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DISCASE Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Attorisclerisis Reval Failure 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No Hospital or Attending Physician: The 1 Yes 2 No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2 No Hospital: Other: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No death. М 2 Accident after death Investigation completed filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Our tifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check within 2 To the I only one) 29b. Signature and title of cause of death (Item 23a) (Type, Print) 30. Name and IW-6 31. Date filed (Month Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien **1 -** For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ $\mathbf{J}_{\mathbf{u}}^{\text{Month}}\mathbf{J}_{\mathbf{y}}^{\text{h}}$ 06 Day 20ÎÎ 15:20P M Joyce V. Walker Medical 4a, Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hospital Center Cheverly Prince George's 5. Social Security Number 6. Sex Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** 1 □ M 2 🖰 F Days Hours 190-34-3527 67 **Director** 09/27/1943 NC Usual Residence of Decedent 28a-f shov at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland Director iral", or items 23a or 28a-f s Examiner must be notified MD Prince George's Upper Marlboro 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20774 633 Mt. Lubentia Ct. West death with United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married 1 ☐ Yes 2 😾 No If Yes, Give Year or Dates. Maryland 21215-0036 72 hours after 1 ☐ Yes 2 🔀 No Specify Black "natural", 3 Widowed 4 Divorced Specify: Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business Industry 12 should be filed within remaith and Mental Hygiene.
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1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 pronths? Month Day Year Pregnant at time of death signed by the a d be detached f 9 Unknow 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? certificate Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 XNo 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this nours after death.

neral Director: After the filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 2 🗌 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a

To the Funeral C Hospital Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manifestation of the cause (s) and manifestation of the cause (s) and manifestation of the cause (s) and the cause (29b. Signature and title of certifier 29c. License number , (Month gerson who completed cause of death (Item 23a) (Type, Print)

State Registrar

5 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Day 2011 Physician/ Month Robert D. 10:30A Warren July Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4225 Southwinds Place #307 White Plains 8. Date of Birth (Month, Day, Nov. 27 . Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Hours 1 XM 2 | F 67 Yrs. Director 213-46-6213 Maryland Usual Residence of Decedent 28a-f show aţ 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified 1X Yes 2 No Charles White Plains 10e. Street and Number 10g, Citizen of What Country? Funeral 4225 Southwinds Place #307 20695 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 72 hours after 1 Yes 2 No Specify: If Yes. Give Specify: Black "natural", 3 X Widowed 4 Divorced Completed Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other trainmain. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Maintenance WSSC Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ္ဝ Mitchell Warren Estelle Dyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10642 Quillback Waldorf, MD, 20 Street DeSales R. Warren/son 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Lincoln Mem. Cemetery 7/18/11 Suitland, MD of Funeral Service Licensee 22. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, MD. 20746 23a. Par 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shack, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph sician/ disease or condition Lung Cancer Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): burial-transi Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physiciar Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 68760 the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant Box 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ 1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown in the past 12 months? signed by the atte Day Year Pregnant at time of death g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes Records, 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Division of Vital completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other: 1 Yes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural work? 1 ☐ Yes 2 ☐ No 5 Pending injury fter death. 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined City or Town, State) 24 hours Medical Lertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Cerpfying Nurse Practioner: To the best of my knowledge dist the time, date and place, and due to the causo(s) and manner as state 29b. Signature itle of/

Registrar
DHMH 17 Rev 7/2009

State

John

31. Date filed (Month, Da

6104 Old

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

00059658

Branch Ave., Temple Hills, MD 20748

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

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Completed

Be

r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at

marked other Ith and Mental Hv

Health a

permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr.

Maryland 21215-0036

Baltimore,

and burial-1 attending physician the page 2 s certificate I

requires that the death certificate be executed

Box 68760,

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Division or Vital Records,

this

After

completely filled in by

12

death.

or Attend after death Director:

within 24 hours a

To the Funeral I To the Hospital

Physician/Medical 2 Completed

Certification:

Medical

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🗓 No 9 Unknow

25. Was case referred to medical examiner? 1 Yes 2√ No 27. Manner of Death

5 Pending investigation 6 ☐ Could not be

28a. Date of Injury (Month, Day Year)

28b. Time of 28c. Injury at Work?

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1X Natural

2 Accident

3 Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifié

29c. License number

29d. Date signed (Month, Day, Year) 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TULI, M.D.10810 DARNESTOWN RD. SUITE 202, GAITHERSBURG, MD. RAMAN R.

State Registrar

32. Registrar's Signature 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 7:20 P.M JULY 2011 CHARLES LOUIS ANGLE Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner BALTIMORE PICKERSGILL ASSISTANT LIVING TOWSON 9. Birthplace (State or Foreign 8. Date of Birth If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Min. 10/1/1926 MARYLAND 1XXM 2 □ F 84 Director 219-20-9631 Yrs Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Directo 1 Yes 2 No TOWSON BALTIMORE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21204 Apt. 206 615 Chestnut Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Completed by If Yes, Give Year or Dates. WWII 1 ☐ Yes 2 🗷 No Specify: Specify: WHITE "natural", 3 Widowed 4 Divorced 1 and 2 should be filed within 72 hours of Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) COCA COLA BOTTLING Elementary/Seconday (0-12) College (1-4 or 5+) MANAGEMENT 11TH GRADE Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be filt. Ith and Mental H 2 CHARLES ANGLE CECEILIA MITCHELL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Page 1 and 2 sl ment of Health a ant: If item 27 is 21234 PARKVILLE, MD 11 RANGER COURT CATHY GANSERT/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date or other place Department of Important: If it any injury or o 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 7/30/2011 BALTIMORE, PARKWOOD CEMETERY 4 Donation 5 Other (Specify) 22. Name and Address of FacilityTHE JOHNSON FUNERAL HOME, P.A. 21. Signature of Fpneral Service Licensee MO1139 21286 8521 LOCH RAVEN BLVD. TOWSON, MD art 1. Enter the disease, or comply ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ JTe MINUTE disease or condition Medical resulting in death) **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) Mg Exam the burial-transit Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month ate has been signed by the page 2 should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by OBSTRUCTIVE PULMONARY DIST 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? ARTERY DISPASE 24a. Was an autonsy certificate 1 Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) To Be examiner? SSISTEL Other: 4 Nursing Home 5 Residence 2 🗖 No 1 Inpatient 2 ER/Outpatient 3 DOA this • Hospital or Attending Phys 24 hours after death.
• Funeral Director: After this leted filled in by the funeral di 27. Manner of Death 28a, Date of injury 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at (Month, Day, Year) 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 2 Accident 3 Suicide 4 Homicide To the Hospital or Atter within 24 hours after dee To the Funeral Director completed filled in by th 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) City or Town, State) Medical crtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination allow introsugation, irring opinion, coats and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 29c. License number 041 30. Name address of person who completed cause

DHMH 17 Rev 7/2009

State Registrar

Maryland 21215-0036

Baltimore,

68760

Box (

P.O.

Records,

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 24143 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July 20^Yf Y 12:15 P M David Stanley Abramowich 4a. Facility Name (If not institution, give street and number) 4h City Town, or Location of Death 4c. County of Death Howard 6512 Deep Run Pkwy Elkridge If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Mooth, Day, March 1, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 X M 2 □ F Months North Carolina 64 237-74-0765 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 X No MD Howard Elkridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21075 USA 6512 Deep Run Pkwy 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2X No Specify: 3 ☐ Widowed 4 K Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) restaurant industry chef unk unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Burkhardt - friend 6512 Deep Run Pkwy; Elkridge, Maryland 21075 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ⚠ Other (Specify) in state 22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore St; Baltimore, MD 21201 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, a heart failure. List only one cause on each line. Immediate Cause (Final ARTERY CRONARY disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to or as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? SEVERE Probably 4 Unknown 1 □ Yes 2 □ No PVD 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Other: 4 Nursing Home 6 Residence 6 Other (Specify) 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

Physician /Medical Examiner Examiner law requires that the death certificate be executed

Physician

/Medical

Examiner

Director

Funeral

2

Completed

Be ပ

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Mulical Expriner must be rotified at once.

Baltimore, Maryland 21215-0036

burial-trar attending physician for use as the buria signed by the a d be detached for has certificate

Physician/Medical \$ Completed Hospital or Attending Physician: '24 hours after death.
Funeral Director: After this certifica funeral director, Be Certification: To filled in by

Division of Vital Records, P.O. Box 68760,

MYPERTENSION

25. Was case referred to medical examiner? 1 ☐ Yes

27. Manner of Death 1 Natural 2 Accident

3 Suicide 4 Homicide 29a. Certifier

(Check only one)

5 Pending investigation

6 Could not be determined

28a. Date of Injury (Month, Day, Year)

and manner stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Signature	and	title	of	cer	tifie
		-	•		5

Enor MO

shakunmala

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

90.053150 JULY 20 2011 650 Senticgo Rd Suite 110, Columbus

31. Date filed (Month, Day; Year)

29b

Medical

upre

Registrar

To the Hospital of within 24 hours at To the Funeral D

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	death items ner m		11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13. V	Was Decedent of Hi f Yes, specify Cuba		Specify Yes or No-	14.	Race - Ame	rican Indian,
36	after (I", or xamir	d by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 ☐ If Yes, Give		II/ ₁	Yes 2 XNo		no moun, oto.,		Black, White	
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and	ntal H ed ot ever	To B	17. Father's Name (First, Middle, Last) Proctor Eldridge	Adama					ame (First, Middle, I	Maiden Suri	name)	
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ore	of He		20a. Method of Disposition 1		20b. Pla	ace of Dispo	sition (Name of natory or other place		Date			Town, State
ij	Page tment tant: jury o		4 Donation 5 Other (Special		1	Lawn Me	morial Park	July	29, 2011	Rocky	ville.	Maryland
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service France Robert A. Pumphrey Funeral Home, Rockville, Inc. 300 W. Montgomery Avenue, Rockville, MD 20850									
			23a. Part 1. Enter the disease, or com			Do not ente	U W. Mont	gomery such as cardia	Avenue, I	Rockvi _{est}	ille,	MD 20850 Approximate
	Physician/		shock, or heart failure. List only o Immediate Cause (Final	ne cause on each line	ł.			,,	,	,		Interval Between Onset and Death
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0	(e) TE (c)		resulting in death) Last Due to (or as a consequence of):									
P.O. Box 68760	eath certificate be attending physic for use as the bu	Physician/Medical	IF FEMALE:			7		-				
9 X	th cert tendir or use	ian/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live Birth	2 🗀 Fetal	death 3	Ectopic pregnanc	у		23d	l. Date of de	*
Bo	e deal the at hed fo	ysic	1 Yes 2 No 9 Unknown	4 ☐ Pregnant at 9 ☐ Unknown	time of de	ath 5	Other (specify)				Month	Day Year
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<u>Ş</u>	Physic this cral dir	2	1 ☐ Yes 2 🛣 No 27, Manner of Death	1 ☐ Inpatie		R/Outpatien	t 3 DOA Othe	4 ☐ Nursing	Home 5 K Resid			cify)
Division of Vital	lor Attending Physician: The law after death. Director, After this certificate has I in by the funeral director, page 2 '	Certificate:	1 Natural 5 Pending 2 Accident Investigation	(Month, Day	Year)	injury	work'		200. Describe no	Jw mjury oc	curred	
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•	1531		30. Name and address of person who c	. \			rint)					
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Examiner	Atlantic	institution, give street and num General Hos	spital		Be	r Location of Deat		4c. Count	Wor	cester
Funeral Director	5. Social Security Number 168-40-9 Usual Residence of Dec		7. Age (In yrs. last t		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birti			thplace (State or Foreign untry) PA
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with the I s 23a or 2 ust be no	10e. Street and Number 241 Rai	msey Avenue			10f. Zip Code	5017		10g. Citizen of	What Co	untry? A
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. Marital Status 1 Never Married 3 Widowed 4	2 X Married Armed For	2X □No e		as Decedent of H res, specify Cuba	ispanic Origin? (Spanic Origin? (Spanic Origin), Mexican, Puert Specify:	pecify Yes or No- po Rican, etc.)		ick, White	nican Indian, e, etc. Ihite
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Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", of any injury or other traumatic event, the Medical Exami DOCE. To Be Completed by		Relationship (Type, Print) Bittner/Wi		9b. Mailing 241	Address (Street a					Code) 15017-1
more, Page 1 and Pert of Hea Int: If item. Ity or other	20a. Method of Disposition 1 Burial 2 Co 4 Donation 5	remation 3 X Removal from	20b. Place	of Disposit	ion (Name of		Date	20c. Location	- City or	
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De executed burial-transit Examiner cal Examiner	Sequentially list condition fan, leading as or condition resulting in death) Sequentially list condition fany, leading to immedicause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death)	cDue to (c	or as a consequence	e of): e of):	c CAP	-DI DUASC	in/an c)ISCAS	E-	Interval Between Onset and Death
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Medical Certificate: To Be Completed by Physician/Medical Exami	IF FEMALE: 23b. Was decedent pregr in the past 12 month 1 Yes 2 No 9 Unknown	1 Live B	ome of pregnancy Birth 2 Fetal dea ant at time of death		ctopic pregnanc	у			ate of deli	very Day Year
uires that t uires that t n signed b uld be deta ed by Pl	Part II. Other significant	conditions contributing to de	ath but not resulting	g in the und	erlying cause giv	en in Part I.				the cause of death?
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clan; clan;	25. Was case referred to examiner?				26. Pla	ice of Death (Chec		2 AC No	I 🗆 res	2 L NO
Physic this c al dire	1 Yes 2 No		npatient 2 ER/C			4 ∐ Nursing H	ome 5 Reside	nce 6 Cth	er (Speci	<u>5</u> 4)
Living of Attending Physician; sa after death. al Director: After this certificed in by the funeral director.	1 Natural 5 □ 2 □ Accident	Investigation	n, Day, Year)			at ? Yes 2 □ No	28d. Describe ho			
he Hospital or Attending P in 24 hours after death. The Funeral Director, After t spleted filled in by the funeral Medical Certificate;	4 ☐ Homicide	building	of Injury - At home, fig, etc. (Specify)			deta - 1 ·	City or Town	, State)		al Route Number,
n 24 h n 24 h ne Fun oleted	(Check 2 🗆 M	ertifying Physician: To the bea edical Examiner: On the basis ertifying Nurse Practioner: To	of examination and	or investiga	tion, in my oninio	n death occurred a	t the time date an	diplace and du	e to the co	ause(s) and manner state
To the within compared to the	29b. Signature and title of		,	3-,-54	29c. License	number PA	2	9d. Date signe		
yen		person who completed cause	of death (Item 23a)	(Type, Prin		06050 Ad.		1/20/	20	
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State Registrar	31. Date filed (Month, Day,	1 Deneva 32. Reg	strar's appatu							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Charlene Buttner State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar Decedent's Name (First, Middle, Last)

Charlene Denise Butler 2. Date of Death 3 Time of Death Physician/ Month **Medical Examiner** 1824 hrs July 25, 2011 4a, Facility Name (if not institution, give street and number) lb. City, Town, or Location of Death 4c. County of Death 320 South Mount Street **Baltimore** N/A 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** oreign Months Days Min. Hours Director 2/25/1962 220-82-9385 1 M 2 X F Country) MD Yrs 49 Usual Residence of Decedent 10a, State 10b. County 10c, City, Town or Location 10d, Inside City Limits 1 X Yes 2 No Baltimore MD . Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Montal Hygiene. "naturall", or items 13s nr 28s-f shu er other transmittered nither than "naturall", or items 13s nr 28s-f shu er other transmitte event; the Medical Examiner must be notified at once N/A 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? 320 S. Mount St. 21223 USA 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married 1 X Yes 4 Divorced If Yes, Give Yaar or Dates: Black 1 Yes 2 No specify: Specify: ੬ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life, DO NOT use retired) Lendmark Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 12th 2 yrs. Loan Specialist Financial Services 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Henry J. Davis Gladys Alexander 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Micaela Alexander MD 21223 320 S. Mount St. Balto., 20c. Location - City or Town, State **Baltimore** 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 1 X Burial 2 Cremation 3 Removal from State Mt crerestory or other clace). 8/1/2011 Randallstown, 4 Donation 5 Other Specify 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March 1101 E. North Ave. Baltimore, MD 21 202 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval failure. List only one cause on each line Between Onset and /Medical Death a, Hypertensive Cardiovascular Disease complicating Liver Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner If any, leading to immediate Due to (or es a consequênce o) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical амендед**Item# 1, per me, g918** #20b, c, perFH, G918, 8 UNPENDED attending physician or use as the burial Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>a</u> 1 Yes 2 No 3 Probably 4 Unknown Completed After this certificate has been funeral director, page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? Yes 2 ✔ No death? 2 No or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) å Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗸 Other: Scene 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 V Natural Director: 5 Pending 1 Yes 2 No death. Accident 2 Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f, Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be determined 24 hours a within 24 hours a To the Funeral I 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Sa 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. July 27, 2011 30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001 OCME 2006

Registrar

ORIGINAL

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) July **Physician** Richard Howard Bartlett 2.4 Day 2019 7:34 A.M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Upper Chesapeake Medical Center Bel Air Harford County 8. Date of Birth (Month, Day, Young) June 11, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 1**X** M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year 1931 Missouri Days 80 T 215-28-1535 Director Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10b. County 28a-f show ortant: If item 27 Is marked other than "natural", or Items 23a or 28a-f shov Injury or other traumatic event, the Medical Examiner must be notified at Maryland Harford County Fallston 1 ☐ Yes 2X No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 406 Summit Drive 21047 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1952-1% Yes 2 □ No 17 Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ 3 Widowed 4 Divorced 16b. Kind of Business/Industry Center Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation. (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other than any Injury or other traumatic event the Manaus Injury or other trauma College (1-4or 5+) 5+ Elementary/Secondary (0-12) 12 Goddard Space Flight Electronics Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Be Elmer Bartlett Edna Stepp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 406 Summit Drive, Fallston, Maryland 21047 Eleanor Bartlett (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 2011 1 Burial 2 □ Cremation 3 □ Removal from State Timonium, Maryland Dulaney Valley Mem. July 28, 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Evans Funeral Chapel & Cremation Services—BelAir Lehm B Newport Drive, Forest Hill, Maryland 21050 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** hours /Medical Due to (or as a consequence of): **Examiner** 7 inon12 sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Examiner Due to (or as a consequence of) Dartlett, Richard or Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) is certificate has been signed by the director, page 2 should be detached 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Dinknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 No Physiclan: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1 Inpatient 1 Yes 2 ER/Outpatient 3□ DOA ည To the Hospital or Attending Phywithin 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral or 27. Man of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certification: 5 ☐ Pending investigation atural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Moretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature nd title of certifier 10032319 cause of death (Item 23a) (Type, Print)

ACK, JRMD UCMC 500 Upper Chesaperke Or BelAie, MO21014 State Registrar DHMH 17 Rev 1/2001

State Registrar

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29b. Signature and title of certifier

HIPPHURCH

29 2011

31. Date filed (Month, Day, Year)

30. Name and ade

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of person who completed cause of death (Item 23a) (Type, Print)

USLLY

29c. License number

Towson

29d. Date signed (Month, Day, Year)

21204

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eastern and the mutified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760x.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

	1 - State Registrar			Certi	ficate of E	Death		Reg. I	lo.	24143
	Decedent's Name (First, Middle, La	rst)					2. Date of D			3. Time of Death
an	Annabell May Bae:	r					July		Day Year	8:05 P.M
cal ner	4a. Facility Name (If not institution, give	e street and number	r)	4	b. City, Town, or	Location of De			c. County of Death	
	Long View Nursing	a Home	,		Mai	ncheste	r		Carrol	1
	5. Social Security Number 6. S		ge (In yrs. last bi		f Under 1 Year	If Under 24 H	rs. 8. Date of B	rth	9. Birth	place (State or Foreign
	216-30-3198	I□M 24117F	77	Yrs.	Months Days	Hours Mi	Auq. 3	ay, rea 1,		vland
	Usual Residence of Decedent									
	10a. State 10b. County		10c. City, Tow	n or Locat	ion					10d. Inside City Limits
먕	Maryland Balt:	imore	P	arkvi	lle					1 □Yes 2/DNNo
ire	10e. Street and Number				10f. Zip Code			10g.	Citizen of What Cou	
a	8608 Oakleigh Roa	ad			2123	34			United S of Ameri	
Funeral Director	11. Marital Status	12. Was Deceden Armed Forces		13. Was	s Decedent of His	spanic Origin?	(Specify Yes or Nerto Rican, etc.)	0-	14. Race - Amer	ican Indian,
正	1 ☐ Never Married 2 ☐ Married	1 □Yes 20				Specify:	erto riicari, etc.)		Black, White,	
Completed by	3 ☑Widowed 4 ☐ Divorced	Year or Dates			1103 \$421140	opeony.			Specify: Wh	ite
ete	15. Decedent's Education (Specify only highest graduation)	ducation	16a	. Deceden	it's Usual Occupa	ition uring most of v	vorkina	1	Kind of Business/Ir	*
횬	Elementary/Secondary (0-12)	College (1-4or	5+)		d of work done do NOT use retired)			1	roll Cou	-
ပိ	llth			اد.	ecretary			1	nool Board	<u></u>
Be	17. Father's Name (First, Middle, Last)					lame (First, Middle	e, Maid	en Surname)	
မ	John Henry Swam					Iova	Walker			
	19a. Informant's Name/Relationship (Type. Print)	198	o. Mailing A	Address (Street a	nd Number or	Rural Route Num	ber, Cit	y or Town, State, Z	ip Code)
	David J. Baer (So	on)					rkville,	MD	21234	
	20a. Method of Disposition AD Burlal 2 □ Cremation 3 □] D f 0	20b. Place o	of Disposition	on (Name of ory or other place	;) .T1:	ıly 30,	20c.	Location - City or T	own, State
	4 □ Donation 5 □ Other (Special		<i>7</i>		an Cemet	,	2011	Ma	nchester,	Maryland
	21. Signature of Funeral Service Licer	nsee					ckhardt	Fun	eral Chap	el, P.A.
	James Silo U	1.6		32	96 Chari	mil Dr.	, Manche	ste	r, MD 211	02
	23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that cause	ed the death. Do	not enter t	the mode of dying	g, such as card	iac or respiratory	arrest,		Approximate Interval Between
	Immediate Cause (Final disease or condition	Tank	lowa	0	- Dr	2000				Onset and Death
	resulting in death)	a. Due to (or a	s a consequence	of):					,	, copa
	TWO CONTRACTOR OF THE PARTY OF	Chr	mu 6	bal	ruelme	Pul	moran	123	rsense	2044
ner	Securation limit renditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a consequence	of):		•	1			
ami	that initiated events	c								
m	resulting in death) Last	Due to (or a	s a consequence	of):						
Medical Examiner		_d								
Med	IF FEMALE:									
	23b. Was decedent pregnant	23c. If yes, outcom	e of pregnancy 2 Fetal death	h 3∏F	ctopic pregnancy				23d. Date of deli	
sici	in the past 12 months? 1 ☐ Yes 2 ☐ No		at time of death		ther (specify)				Month	Day Year
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by	Part II. Other significant conditions	contributing to death	but not resulting i	in the unde	rlying cause give	n in Part I.	23e. Did	tobacc	o use contribute to	the cause of death?
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plet							24a. Wa		24b. Were aut	topsy findings available ompletion of cause of
E							per 1 □ Yes	opsy formed 2	? death?	-
Be C	25. Was case referred to medical					26. Place of D	eath (Check only		0 1 10163	5 🗆 140
	examiner? 1 ☐ Yes 2 🛣No	Hospital:	tient 2 ER/O	utpatient	3 □ DOA Othe	r: 4 🗷 Nursine	Home 5∏ Res	sidence	6 ☐ Other (Spec	e(fv)
Ë	27. Manner of Death	28a. Date of In		Time of Injury	28c. Injury Work	at	28d. Describe			
atio	1 Natural 5 Pending 2 Accident investigation		ay, rear)	пјагу		: ′es 2 □ No				
iţi	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Ir	jury - At home, fa	arm, street	, factory, office				and Number or Ru	ral Route Number,
ert	4 [] Homicide	building, e	etc. (Specify)				City or To	WII, SI	are)	
alC	29a. Certifier 1 Certifying Ph	nysician: To the bes	t of my knowledg	e, death o	ccurred at the tim	ne, date and pla	ace, and due to th	e caus	e(s) and manner as	stated.
Medical Certification: To	(Check only 2 Medical Examone)	miner: On the basis and manner s	or examination ar tated.	nd/or inves	stigation, in my op	oinion, death o	ccurred at the time	e, date	and place, and due	to the cause(s)
Me	29b. Signature and title of certifier	1.1			29c. License	number		29d.	Date signed (Month	, Day, Year)
	My w/n	while	m m	N	1)2	5442		7	12.8/2	
	30. Name and address of person who	completed cause of	death (Item 23a)	(Type, Pri	nt)	1 - 7			1 001 2	
	The law in m	Meter	m17	688	Peole 1	Rd 1	NI.	a Ma	to or	1021157
te	31. Date filed (Month, Day, Year)	32. Regis	trar's Signature	,,		-/	A Act			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? State
Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician/ Boehnlein, Sr. E. Joseph 2011 5:33 Ju1v Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore Towson Gilchrist Nursing Center 9. Birthplace (State or Foreign 8. Date of Birth If Under 1 Year If Under 24 Hrs Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F Days Min Country) Maryland Months Hours 74 216-34-7786 1937 **Director** Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director Dunda1k 1 Yes 2 No MD Baltimore 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a or Funeral 1240 Delbert Ave. United States 21222 or items Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces?

XXYes 2 No
If Yes, Give 1955-5 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Year or Dates. 1955–59 1 Yes XXNo Specify Specify 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Lever Brothers, Corp. Warehouseman 12 Years and Mental Hygie is marked other Be 18, Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Esther Levy Frank Boehnlein 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1240 Delbert Avenue Dundalk, Maryland 21222 19a. Informant's Name/Relationship (Type, Print) Marion E. Boehnlein (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Page 1.
Department of I Important: If it any injury or or once. ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State 7/26/2011 Towson, Maryland Hilltop Service Corp 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc.
Duda-Ruck Funeral Home of Dundalk, 21222 Signature of Funeral Service Licens IN lul Dundalk, Maryland 7922 Wise Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ metastatic bladder disease or condition resulting in death) ancer YEUN S Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Physician: The law requires that the death certificate be executed Cause (Disease or liniury that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed: 2 No Yes Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: ပ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending Natural 5 Pending work?
1 Yes 2 🗌 No after death Director; / Accident Investigation completed filled in by the Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 24 hours a ☐ Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my expirite. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 00070635 wx1 Name and address of person who completed cause of death (Item 23a) (Type, Print) charles st sufe 4005 Baltimore, no 20204 701 2

DHMH 17 Rev 7/2009

Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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	-	For State Registrar	State of M	arylanu /		ate of E			eg. N2011	24151
Physicia Medic	n/	1. Decedent's Name (First, Middle,		Bro	we			2. Date of Deat Month		3. Time of Death 0600M
Examine		4a. Facility Name (* not institution, Tate House Ass:	,)	4b. (Location of Death		4c. County of Dea	
Funeral Director			6. Sex 7. Ag	e (In yrs. last bir 1	thday) If U Yrs. Mon	Inder 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth OCt. 8,	Year) 919 Mai	rthplace (State or Foreign ountry) "Yland
aryland a-f show fied at	. h	Usual Residence of Decedent 10a. State 10b. County MD Ba1	timore	10c. City, Tow	n or Location		D	unda1k		10d. Inside City Limits 1 ☐ Yes 2 X No
h the Ma Sa or 28 be noti	al Dire	10e. Street and Number			101	f. Zip Code	21.2		10g. Citizen of What C	•
ath wii	Funeral	8434 Kavanagl	h Road	Ever in U.S.	13. Was D	ecedent of Hi	212 spanic Origin? (Spe		United St	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 ☐ Never Married 2 ☐ Marri 3 🎇 Widowed 4 ☐ Divorced	Armed Forces?		If Yes,	specify Cubaries 2X No	n, Mexican, Puerto	Rican, etc.)	Black, Wh	
72 hou in "nati Medica	Completed	(Specify only higher	at's Education st grade completed)		i. Decedent's (Give kind of life. DO NO	Usual Occupa f work done d T use retired)	ation luring most of work	ing	16b. Kind of Busines	s Industry
l withir /giene. ner tha t, the l		Elementary/Seconday (0-12) 11 Years	College (1-4 or	5+)	Seamst	ress			Lamm B	rothers
l be filed lental Hy rked ott tic even	To Be	17. Father's Name (First, Middle, L. Vincent Sa	•				18. Mother's Nam	e (First, Middle, M a Pecker		
d 2 should alth and M		19a. Informant's Name/Relationsh Frederick Deav					and Number or Rura rn Road	al Route Number, Baltimo	City or Town, State, 2	(ip Code) 1220
Page 1 and nent of Hes int: If item iny or othe		20a. Method of Disposition 1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (S)		cemete	of Disposition ery, crematory Num Cen	or other plac	e)	Date / 2011	20c.Location - City o	r Town, State Maryland
permit. Departn Importa any inju		21. Signature of Emeral Service C	Pensee				Funeral Ave. Du		Dundalk,	Inc. 21222
Physician/		23a. Part 1. Enter the disease, or shock, or heart failure. List o Immediate Cause (Final disease or condition	complications that cause nly one cause on each lin	d the death. Do e.				or respiratory arre		Approximate Interval Between Onset and Death
Medical Examiner		resulting in death)	a. Du to (or as	a consequence	of):	- Cit	-111			1011
rted 1 Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	b. Due to (or as	a combequence	υtj.					
e be executed ysician and e burial-transit	ā	that initiated events resulting in death) Last	Due to (or as	a consequence	of):					
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi		IF FEMALE: 23b. Was decedent pregrant in the past 12 months? 1 Yes 2 No		of pregnancy 2 Fetal deat at time of death		opic pregnancer (specify)	у		23d. Date of o	elivery Day Year
at the deg d by the g etached	Phys	g Unknown Part II. Other significant conditio	9 Unknown	but not resulting	in the underly	vina cause div	ven in Part I.	23e Did tol	pacco use contribute	to the cause of death?
v requires that been signed be should be deta	ted by									Probably 4 Donknown
The law re cate has be page 2 shi	Completed							24a. Was a autops perfor 1 \(\sum \) Yes	prior to death?	autopsy findings available o completion of cause of les 2 \(\sum \) No
Physician: The this certificate ral director, pag	Be	25. Was case referred to meetical examiner? 1 Yes 2 No	Hospital:			Othe	ace of Death (Chec			TATE
ing Phys After this uneral di	ate: To	27. Manner of Death 1 Autural 5 Pendin	28a. Date of inju		Time of injury	28c. Injury work	4 □ Nursing Ho / at ?	ome 5 Reside 28d. Describe ho	ence 6 ther (Spe ow injury occurred	HOSPICE
To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completed filled in by the funer	Certificate:	2 Accident Investig 3 Suicide 6 Could t 4 Homicide determi	not be 28e. Place of Inj	jury - At home, fa c. <i>(Specify)</i>	M arm, street, fa		Yes 2 □ No	28f. Location (St City or Town	reet and Number or F n, State)	iural Route Number,
Hospital 24 hours Funeral rted filled	Medical	(Check 2 Medical E		examination and/	or investigatio	n, in my opinic	on, death occurred a	t the time, date an	d place, and due to the	e cause(s) and manner stated.
To the within 2 To the comple		only one) 3 Certifying 29b. Signature and title of certifier	Nurse Practioner: To the	best of my knov	vledge, death	29c License	e time, date and pla		cause(s) and manner a	
		30. Name and address of person v	who completed cause of	death (Item 23a)		1	18 10.	٠ ر	1125	12011
n		Genevieve Li	ghtfoot-TA	,		45 De	fense H	wy, And	rapolis, i	4.D.21401.
Stat Registra	e ar	31. Date filed (Month, Day, Year) JUL 29 2011	Denue &	1. par	les					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Day Year **Physician** 5:45 C. Raner Anne JULY 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** KOSEDALE BALTIMORE FRANKLIN SQUARE HOSPITAL If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6 Sex **Funeral** Months Days Hours Min 1 □ M 2 🕅 F 92 Maryland Director 220-01-5705 Dec. 17,1918 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylas Department of Health and Mental Hygiene.
Important; If them 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, its "Modical Examinar must be neathed any Injury or other traumatic event, its "Modical Examinar must be neathed as 1 ☐ Yes 2 No Director MD Baltimore Dunda1k 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 255 Trappe Road 21222 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☐No Specify: þ 31√ Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Years Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Foehrkolb ျှ Mary Ey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Jean Gahan (Daughter) 7129 Cunning Circle Baltimore, Maryland 21220 20a. Method of Disposition Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Sacred Ht. of Jesus Cem. 7/28/2011 Dundalk, Maryland 4 ☐ Donation

5 ☐ Other (Specify) 21. Signature of Juneral Service Licensee Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease shock, or heat failure. isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, illust. List only one cause on each line. Immediate Causs (Final **Physician** CLOSTRIDIUM DIFFICILE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner FIBRILLATION TRIAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Year 4 Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown à signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 s autopsy performed certificate 1 ☐ Yes 2 ☐ No Division of Vital 1 ☐ Yes 2 No 25. Was case referred to medical director Be 26. Place of Death (Check only one) examiner? Other: 4 \sum Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) Hospital: 1 ☐ Yes 2 🖼 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 Natural 5 Pending n 24 hours after death.

In Funeral Director: A pletely filled in by the fu death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only within 24 29b. Signature and title of certifier 29c. License number D0067271 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 FRAKLIN SQUARE DRIVE BALTO, MD 21237 State JUL 29 2011 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend items 23b, c per doc g917 7-29-11 vt.
State of Maryland Department of Health and Mental Hygiene State
Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ TULY 2011 ARTHUR NORMAN BLOCK Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** County of Death BAUGIMORE MASHINGTON MEDICAL CENT AMNE 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Sex 1 XM 2 □ F Hours 127374923 **Director** Yrs 578-22-7808 DC Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. or 28a-f shov 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 🗌 Yes 2 🛭 No MDANNE ARUNDEL ANNAPOLIS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral "natural", or items 23a 1518 ENYART WAY, 21409 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?
1 ☑ Yes 2 ☐ No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married altimoré, Maryland 21215-0036 1 Yes 2 No Specify. Completed 3 Divorced Specify: WHITE Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) GENERAL AGENT INSURANCE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ SAMUEL BLOCK SYLVIA GORFAIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 MARILYN BLOCK / WIFE 1518 ENYART WAY, #201, ANNAPOLIS, MD 21409 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) KNESSETH ISRAEL 07/27/2011 ANNAPOLIS, MD Signature of Fune A Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, ANNAPOLIS, MD 21409 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Diabetes Mellitus Sequentially list conditions. Examine Due to (or as a consequence of): it any, reading to immediate cause. Enter Underlying the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death. the Period of the Attending physician and the Funeral Director: After this certificate has been signed by the attending physician and burial-transi Cause (Disease or linjury Arthritis that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Pregnant at time of death n signed by the at id be detached fo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 No prior to completion of cause of death? 2 🖵 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manual of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signa 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) 20161 JABA 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		_	State of Ma State Amend Items 26,27 per Registrar	dr.,g91Z.(17/28/2011 dhb	Reg.	N2011 24154
	Physicia Medic		1. Decedent's Name (First, Middle, Last) DAVID LEE	BLESSIN	4	2. Date of Death Month J U L	Day Year 11:00 A M
	Examin		4a. Facility Name (if not institution, give street and number) Staybridge Suites		4b. City, Town, or Location of Death Columbia		4c. County of Death Howard
	Funeral Director			(In yrs. last birthday) Yrs.	If Under 1 Year If Under 24 Hrs.	8. Date of Birth Dec 29 19	9. Birthplace (State or Foreign Country) W. Va.
	aryland ia-f show ified at	ector	Usual Residence of Decedent	10c. City, Town or Loc Sykesvill			10d. Inside City Limits 1 ☐ Yes 2 ∑ No
	with the Ms 23a or 28 ust be not	Funeral Director	10e. Street and Number 5918 Old Washington Road		10f. Zip Code 21784	10g U	. Citizen of What Country? S
9036	is filed within 72 hours after death with the Maryland tal Hyglene. Ed other than "natural", or items 23a or 28a-f show other than matural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		11. Marital Status 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Decedent E Armed Forces? 1 ☐ Yes 2 X If Yes, Give Year or Dates.		Nas Decedent of Hispanic Origin? (Spef Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. White Specify:
1215-0	nin 72 hou ne. than "nat le e Medica	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5	(Give i	dent's Usual Occupation kind of work done during most of work O NOT use retired) ident/Owner	ing	b.Kind of Business Industry nterlock Steel Workers
Maryland 21215-0036	should be filed within and Mental Hygiene. is marked other tha raumatic event, the N	To Be C	17. Father's Name (First, Middle, Last) Raymond Blessing	Ties	18. Mother's Nam	e (First, Middle, Maid y Mae Wal	den Surname)
Maryl	d 2 should be fill alth and Mental of 27 is marked of er traumatic eve		19a. Informant's Name/Relationship (Type, Print) John Blessing son		ng Address (Street and Number or Rura 46 Berbei Road, W		
Baltimore,	permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		sition (Name of natory or other place) ge Mem Park Jul 3		c. Location - City or Town, State 1kridge, MD
Balt	permit. Departi Import any inji		21. Signature of Funeral Septice in See		2. Name and Address of Facility Bur		
	Physician/ Medical Examiner		resulting in death) Due to (or as a		-9:V		Approximate Interval Between Onset and Death
0.	physician and the burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	a consequence of):			
Division of Vital Records, P.O. Box 68760	th certific ttending or use as	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	2 Fetal death 3 L	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
Ís, P.Ó	uires that the dea n signed by the a uld be detached f	ρ	Part II. Other significant conditions contributing to death b	ut not resulting in the u	underlying cause given in Part I.		cco use contribute to the cause of death?
Record	sician: The law require certificate has been si irector, page 2 should	Completed	ES. Western described			24a. Was an autopsy performe	
Vita	nysiciar iis certif directo	To Be	25. Was case referred to medical examiner? 1 Yes 2 □ No No Hospital: 1 □ Inpati	ent 2 ER/Outpatie	26. Place of Death (Chec ont 3 DOA Other: 4 Nursing He		ce 6X Other (Specify) Hotel
ion of	utending Ph death. ctor: After th y the funeral	Certificate:	27. Manner of Death 1 Natural 5 Pending (Month, Day 2 Accident Investigation 3 Suicide SColld not be	ry 28b. Time of injury	f 28c. Injury at work? M 1 □ Yes 2 □ No	28d. Describe how i	injury occurred
Divisi	oital or Attencurs after death		4 ☐ Homicide determined 28e. Mace of inju- building, etc			City or Town, S	
	To the Hospital or A within 24 hours after To the Funeral Dire completed filled in b	Medical	only one) 3 Certifying Nurse Practioner: To the	xamination and/or inves	tigation, in my opinion, death occurred a death occurred at the time, date and pla	t the time, date and pope, and due to the car	place, and due to the cause(s) and manner stated. use(s) and manner as stated.
	To wit		29b. Signature and title of certifier PH	YSICIAN	29c. License number D 50 4 04	29d	Jul 27, 2011
_				00 Century	Plaza, 10632 Lit	tle Patux	21044 Pkwy, Columbia MD
	Sta Registr		31. Date filed (Month, Day, Year) JUL 2 9 2011	ar's Signature face	Kal		

11-05546 Andrew Bauer Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2011 24155

	1- For State Registrar		Cert	ificate of	Death			Reg. N	No.		
Physician/ Medical Examiner		iddle,Last)		Bauer			Month	of Death Da 25, 2011	ay Year	3. Time o	
	4a. Facility Name (if not insti Sassafras River	ution, give street and n	umber)		4b. City, Town, o Kennedyvi		of Death		4c. County o Kent	f Death	
Funeral Director	5. Social Security Number 486-80-008	1[X]M 2[]F	7. Age (In yrs. las		If Under 1 Ye Months Da		Min	of Birth(M		9. Birthplace (Si Foreign Miss Country) 1 S	ate or souri
daryland 184 once. ector	Usual Residence of Deceder 10a. State PA			own or Locati	ester					1Y	le City Limits
the Maryland 3a or 28a-f sh otified at once	10e. Street and Number 927 Thorne	Drive			10f. Zip Code 19382	2			S.A.	at Country?	
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyggiene. Important: If item 27 is marked other than "natural", or items 23a or 28s-f sho injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	45 Davidowed 4 2	Married Armed F 1 Yes Divorced If Yes, Give Ye or Dates:	2 X No	If You	es, specify Cuba Yes 2 X No t's Usual Occupa	o specify:	in? (Specify Yes Puerto Rican, et and of work done	c.)	White	American Indian etc. White iness/Industry	, Black,
nore, MD 21215-0036 segs 1 and 2 should be filed within 72 hours at nt of Health and Mental Hygiene. tt: If item 27 is marked other than "natural other traumatic event, the Melical Examin To Be Completed by	Elementary/Secondary (0-	12) College (1-4 or 5+)	during me	ost of working life	e. DO NOT	use retired)	(ruction	
ID 21215-0036 should be filed within 7 and Mental Hygene. 7 is marked other than natic event, the Melical To Be Compile	Michael	J. Ba	uer			Susa		C	opped	-	
e, MD 21 1 and 2 should Health and Me item 27 is ma	Susan J, B			927	Thorne	Dr.	West C	hest	er, F	, State, Zip Code a. 193	30
Baltimore, M permit. Pages 1 and 2 Department of Health Important: If item 2 injury or other fraum	20a. Method of Disposition 1 Burial 2 Crema 4 Donation 5 Othe				ition (Name of coner place) Co. Cr		Date 7-27-			City or Town, Star Chester	
Baltin permit. Departm Imports	21. Signature of Funeral Sen	rice Licensee		22. N	ame and Addres	ss of Facility	Josep ing St	h N Ba	Zann lto.	ino Jr. Md. 21	F.H.
Physician /Medical :xaminer	23a. Part I. Enter the disease failure. List only one ca Immediate Cause (Final dise	use on each line.	caused the death. D	o not enter th	ne mode of dying	, such as ca	ardiac or respirate	ory arrest, s	shock, or hea	rt Approxi Betwee	mate Interval n Onset and Death
zxammer	or condition resulting in deat		a consequence of):								
ted Insit Examiner		c.	a consequence of): a consequence of):								
		d	,								
Box 68760, the death certificate be executly the attending physician any ched for use as the burial - transparent of the participan/Medical		n the 23c. If yes,	nant at time of deat	2 Fet	al death 3 ner (Specify)	Ectopic	pregnancy		23d. Date of o	delivery Day	Year
ires that the da signed by the detached:	•			ulting in the u	nderlying cause	given in Par	rt I. 23e.			Probably 4	
Records, i. The law requires fircate has been sign, page 2 should be Completed							- _	Was an autopsy performed	24b. W	ere autopsy findii fior to completion eath?	ngs available
Vital Rec rician: The his certificate director, page		Honnitol: -					Check only one)	Yes 2	11111	✓ Yes 2	No No
ing Phy After th funeral	1 Yes 2 No 27. Manner of Death	28a. Date	of Injury 2 h. Day,Year)	R/Outpatient 28b. Time of Ir FOUND: 1050 hrs	njury 28c. Inju	Other at Work? Yes 2	Subject		injury occurre		
Division c spital or Attending tours after death, neral Director: Affilled in by the fun Certification	3 Suicide 6 (could not be 28e. Place	ce of Injury - At hom	ne, farm, stree	t, factory, office	building, etc	or T	own. State)		r or Rural Route N e, MD	lumber, City
Division To the Hospital or Attention 24 hours after death within 24 hours after death To the Funeral Director: completely filled in by the		Physician: To the be Examiner:On the basis and manner:	of examination and								
• F F F 8	29b. Signature and title of ce	tifier				se number			d. Date signe uly 26, 201	d <i>(Month, Day,</i> Ye	ear)
	30. Name and address of per Donna M. Vincenti,	MD Assistant I	Medical Exami	ner 900	W. Baltimore	e Street,	Baltimore, M	D 21223	3		
State Registra	31. Date filed (Month, Day, Ye	9 2011 32.8	distrar's Signature	1	RI				p.		
DHMH 17 Rev 1/2001		OCME		ORIGINAL	- 53						

11-05574 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Leon J. Cooper State of Maryland / Department of Health and Mental Hygiene 2011 1- For State Certificate of Death Reg. No. Registrar Decedent's Name (First, Middle,Last)
Leon
J. Physician/ 2. Date of Death Month Day July 26, 2011 Cooper Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b City, Town, or Location of Death 4c. County of Death Kernan Hospital **Baltimore Baltimore County** 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 6. Sex 7. Age (In yrs. last birthday) **Funeral** 168-36-0764 Months Days Hours Director 1X M 2 F 67 1/13/44 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Howard MD Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
injury or other tranmatic event, the Medical Examiner must he notified at once. Elkridge Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6834 Montgomery Road 21075 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Armed Forces? 1 X Never Married 2 Married White, etc. Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Yeer 1 Yes 2X No specify: Specify: Completed by 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Data Systems Analyst Dept. of Defense 10 0 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Julia Ann Urszta Be Alexander Cooper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward Cooper Brother 6834 Montgomery Road, Elkridge MD 21075 Physician /Medical xaminer Medical Certification: To Be Completed by Physician/Medical Examiner

To the Funeral Director; After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death cartificate be executed within 24 hours after death

1 Burial 2 Cremation 3 XX Removal from State		(Name of cemetery,	Date	20c. Location - City or 1	Town, State
	crematory or other pl	lace)	7/30/11	Pleasant	Hilla Da
4 Donation 5 Other Specify:	Jefferson Me	an. Park	7750711	rieasant	niiis PA
21 Signature of Funeral Service Licensee Victor P	Doda 22 Name	and Address of Facility			
VICCOL	Char.	les L. Stev	ens Funeral	Home, Inc.	
1014	1501	East Fort	Avenue, Bal	Home, Inc.	21230
23a. Part I. Effer the disease, or complications that caused the	death. Do not enter the mo	ode of dying, such as c	ardiac or respiratory arre	st, shock, or heart	Approximate Interval
failure. List only one cause on each line.					Between Onset and
	rosclerotic Cardiova	scular Disease			Death
or condition resulting in death) Due to (or as a consequ	ence of):				
h h					
Sequentially list conditions, if any, leading to immediate Due to (or as a consequence)					
cause. Enter underlying Cause	ence or):				
(Disease or injury that initiated C.					
events resulting in death) Last Due to (or as a consequ	ence of):			1	l
d.					
UNPENDED AMENDED					
AMENDED .					
IF FEMALE: 23c. If yes, outcome	of pregnancy			23d. Date of delivery	
23b. Was decedent pregnant in the past 12 months?	2 Fetal de	eath 3 Ectopic	pregnancy	Month D	ay Year
Pregnant at tim	e of death 5 Other	(Specify)			
1 Yes 2 No 9 Unknown 9 Unknown	o 🗀 Other (
Part II. Other significant conditions contributing to death be	ut not resulting in the under	lying cause given in Pa		bacco use contribute to t	
Chronic osteomyelitis, diabetes mellitus			1 Yes	2 No 3 Prob	ably 4 🗹 Unknown
			104-114	- 1045 144	. F. B
			24a. Was a		opsy findings available ompletion of cause of
		-	perfor	med? death?	omplotion or daddo of
1			1 ✓ Yes 2	No 1 Ve	s 2 No
. I					
25. Was case referred to medical		26.Place of Death	(Check only one)		
examiner? Hospital:	2 EB/Outpationt 3		· , , , , , , , , , , , , , , , , , , ,	2014-00-0	
examiner? 1 ✓ Yes 2 No Hospital: 1 ✓ Inpatient		DOA Other	Nursing Home 5 1	Residence 6 Other:	
examiner? 1 Yes 2 No 27. Manner of Death About 1 Inpatient 28. Days of Park Carl			Nursing Home 5 1	Residence 6 Other:	
examiner? 1 ✓ Yes 2 No Hospital: 1 ✓ Inpatient		DOA Other	Nursing Home 5 1		
examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation Phospital: 1 Inpatient 28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	DOA Other 2 28c. Injury at Work	Nursing Home 5 I	ow injury occurred	
examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation Phospital: 1 Inpatient 28a. Date of Injury (Month, Day, Year)		DOA Other 2 28c. Injury at Work	No No 28f. Location (S	ow injury occurred	
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examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined 29a. Certifier (Check only 1 Certifying Physician: To the best of my king Could not be determined)	28b. Time of Injury 7 - At home, farm, street, factors nowledge, death occurred a	DOA Other 1 28c. Injury at Work 1 Yes 2 ctory, office building, et	Nursing Home 5 1 Response 1 Response 2 28d. Describe here No 28f. Location (Sor Town, State) ace, and due to the cause	ow injury occurred treet and Number or Rurate) e(s) and manner as state	ral Route Number, City
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examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 29a. Certifier 1 Certifying Physician: To the best of my known 2 Medical Examiner: On the best of examinand manner stated. 29b. Signature and title of certifier	28b. Time of Injury 7 - At home, farm, street, factors anowledge, death occurred a ation and/or investigation, in (Item 23a) I Examiner 900 W.	DOA Other 1 28c. Injury at Work 1 Yes 2 ctory, office building, et at the time, date and plain my opinion, death oc 29c. License number O.C.M.E.	Nursing Home 5 1 Representation (Sor Town, State, and due to the cause curred at the time, date at	treet and Number or Rurate) a(s) and manner as state and place, and due to the 29d. Date signed (Mon July 26, 2011	ral Route Number, City ad. a cause(s)

24156

3. Time of Death

0235 hrs

10d. Inside City Limits

1 Yes 2X No

Foreign Country)

White

Stat Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Nadine В. Carr 1:30 A M. Medical 4b. City, Town, or Location of Death **Glen Burnie** 4a. Facility Name (if not institution, give street and number 4c. County of Death **Examiner** Baltimore Washington Medical Center Anne Arundel Social Security Number Age (In yrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 231-40-1644 1 □ M 2 🔽 Months Days Hours 8/27/35 75 Director Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director MD Baltimore Halethorpe 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2828 Tennessee Avenue Completed by Funeral 21227 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygene. Ilmportant: If item 27 is marked other than "natural", any injury or other traumatic name. If Yes, Give White 3XXWidowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ George Hardy Beulah Snyder 19a. Informant's Name/Relationship (Type, Print)
Linda N. Kniess / Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 808 Elmhurst Road, Severn MD 21144 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 7/29/11 Hanover Maryland Ardent Crematory 4 Donation 5 Other (Specify) of Funeral Service Licensee Victor P. Doda Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Avenue, Baltimore MD 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Pregnant at time of death Month Day Year signed by the a 1 Yes 2 L 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2: autopsy performe 1 Yes 2 No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ၉ 1 Tes 1X Inpatient 2 ER/Outpatient 3 DOA Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 5 Pending work?
1 Yes 2 No Accident Investigation within 24 hours after death

To the Funeral Director: / Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a, Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. the l only one) 29b. Signature and title of certifie 29c. License numbe son who completed cause of death (Ite: State 2 9 2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City Town, or Location of Death 4c. County of Death **Examiner** Northwest Seasons Hospice Randallstown Baltimore 9. Birthplace (State or Foreign Country) MD Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Months (Month, Day, Year) 09-28-60 1**X**□ M 2 □ 50 215-28-1544 Director Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f sho idical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland Director MD NA Baltimore XX Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 754 W. Saratoga Street 21201 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. African 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify 3 Widowed 4 Divorced Specify:American Completed Year or Dates Department of Health and Mental Hygiene. amportant: If item 27 is marked other than "natur amportant: If item 27 is marked other than "natur ampingury or other traumatic event; the Medical once. 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 10th Grade College (1-4 or 5+) Kibby's Restaurant Cook Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Young ပ Earl Curtis Willean 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Henrietta Ellis-Sister 2011 Clifton Avenue Baltimore, MD. 21217 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial 2 ★ Cremation 3 ☐ Removal from State Date 20c. Location - City or Town, State OnSite Cremation | 07-28-11 Baltimore, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Wylie Funeral Home P.A. 21. Signature of Funeral Service Licensee 638 N. Gilmor Street Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition neumoni Medical resulting in death) as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin that initiated events signed by the attending physician and i be detached for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director.

To the Funeral Director there this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the burn of the funeral director, page 2 should be detached for use as the burn of the funeral director, page 2 should be detached for use as the burn of the funeral director. Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Day 4 ☐ Pregnant at time of death 9 ☐ Unknown g 🗌 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Red I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 X No Yes 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2 No 1 🗆 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of De th 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 1 Natural 28d. Describe how injury occurred work? injury 5 Pending Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 29b. Signature and til

Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type,

DHMH 17 Rev 7/2009

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are 2 pible. 24 | 59 amend item 19a per fh 917 7-29-11 vt. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ atherine Month JULY Carrington 5:10 AM 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death AGNES HOSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months | Days | Hours | Min. (Month, Day) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 73 Yrs. **Funeral** 9. Birthplace (State or Foreign 48 409 1 M 2 Months Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f ehromany injury or other traumatic event, the Machinal Exp. 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21229 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married by Yes 2 No 1 Yes 2 No If Yes, Give Year or Dates. Specify: Black 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) conday (0-12) College (1-4 or 5+) ook To Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) leton Walker Mary . Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Balto MD Kevin 21229 Charles Carrington- Son 1110 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cremator Petro atonsville, mo 21. Signature Funeral Servic Lice 22. Name and Addr s of Facility 270 Fredhilton Pass Barb mo 21229 nter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Sause (Final Ischemic Stroke Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of); Examiner Status Epilepticus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year ate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CARDIOMYOPATHY DILATED 1 ☐ Yes 2 📈No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? performed' 2 🗷 No Yes 2 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending | 24 hours after death. 1 Natural Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check only one) 29b. Signature and title of certifier unculata DD P25481 27 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RIA CALATA 700 CATON MO 21229 AVE BAUTIMORE JUL 29 2011 32. Registrar's Signature State Registrar

CARRINGTON

ATHERINE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last 201 Physician/ on Medical 4b. City, Examiner len hinston ltimore 8 Date of Birth 1 Year If Under Age (In yrs. last birthday) **Funeral** Maryland 0497257 1944 1 😾 M 2 🗆 F Months Hours 67 212-42-8539 Director Usual Residence of Decedent 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event: the Marken 10c. City, Town or Location 10a. State 10h County Director 1 Yes 2 No Pasadena Anne Arundel Cd MD 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number Funeral U.S.A. 21122 286 Caldwell Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Never Married 2 Married þ Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: Specify: If Yes, Give Year or Dates Black 3 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Self Employed Home Improvement 12th Grade Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Lilian Thompson Caldwell George 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 286 Caldwell Rd., Pasadena, MD 21122 Cynthia Caldwell(wife) 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State on-site Crematory 08/02/11 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Joseph Adness of Brown Jr. Funeral Home 21. Signature of Funeral Service Licensee 2140 N. Fulton Ave., Baltimore, MD21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition 30 minutes Due to (or as a c requence of): Physician/ Medical resulting in death) £xaminer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): Cause (Disease or liniury sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): attending physician The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as the IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death asn 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Day Year in the past 12 months?
1 ☐ Yes 2 ☐ No for Pregnant at time of death the q 1 Inknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 🗌 No 3 Probably 4 Unknown 1 Tyes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has perform rmed? 2 □ No 1 Yes 2 No Yes certificate 26. Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 No 1 \(\text{Yes} \) Inpatient 2 ER/Outpatient 3 DOA မ Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certificate: 1 Natural 2 Naccident 5 Pending 2 🗌 No Investigation 3 Suicide
4 Homicide 28f. Location (Street and Number or Rural Route Number, 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Certifying Nurse Practioner: the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 6824

Registrar

State

(Item 23a) (Type, Print)

en Burnie, MD 2061

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 23a-d.pt. II per doc g918.8-8-11 vt. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 20:07 P M Ronald Earl Coward July 2011 Medical 4a. Facility Name (if not institution, give street and number Examiner Town, or Location of Death 4c. County of Death HOSDita Marylano senera timore N/A 8. Date of Birth (Month, Day, Year) 02/03/1948 6. Sex If Under 24 Hrs. 7. Age (In vrs. last birthday) If Under 1 Year **Funeral** 9. Birthplace (State or Foreign 1**√** M 2 □ F Months Min Carolina Days 216-52-4396 Yrs **Director** 63 Usual Residence of Decedent f show 10a. State 10b. County be filed within 72 hours after death with the Maryland injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director · 28a-f 1 X Yes 2 No N/A MD Baltimore 10e. Street and Number 10g. Citizen of What Country? ō 10f. Zip Code Funeral items 23a 1100 Bolton St. Apt 312 21201 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ò þ 1 ☐ Yes 2 🙀 No Maryland 21215-0036 If Yes, Give Year or Dates "natural", 1 ☐ Yes 2x No Specify Specify: Black Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) 11th Grade College (1-4 or 5+) House Keeping St. Agnes Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. unk Esther unk 19a. Informant's Name/Relationship (Type, Print) (wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21201 Donna M. Jones-Coward 1100 Bolton St., Apt .312, Baltimore, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) on-site Crematory 07/28/11 Baltimore, MD 21. Signature of Funeral Service Licenses 30389914dff.offBfown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD2 Lance MD21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Severe Anoxic Encephalapathy Immediate Cause (Final Onset and Death Ph sician/ disease or condition resulting in death) W: HidrawH OF Medical Due to (or as a consequence of):
Acute Respiratory (3) Examiner Sequentially list our office of Examiner if any, leading to immediate cause. Enter Underlying Pulmonary Edema, Cause (Disease or iinjury Failure the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of):

CEnd Stage Ren Stage Renal Disease by Physician/Medical Division of Vital Records, P.O. Box 68760 TILL MONICE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed certificate has been irector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No Yes 25. Was case referred to medical funeral director Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗹 No မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending work Accident Suicide 1 Yes 2 No a er death Director: / d i by the f Investigation the Funeral Direc. 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho

To the Fune

completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar (Check only one)

31. Date filed (Month, Day, Vear)

2 9 2011

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Signature

29d. Date signed (Month, Day, Year)

7/24/

29b. Signature and title of certifier signing on behalf of Ds. Vermo 29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 For
State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July Physician/ 27, 2011 Chapman 3:45 A.M Carol Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 17517 Wheatfall Drive Montgomery Derwood 9. Birthplace (State or Foreign If Under 24 Hrs. . Social Security Number . Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days May 6, 1937 1 🗆 M 2 🕱 F Months Hours Min. Virginia **Director** 227-48-9364 74 Usual Residence of Decedent or 28a-f show ا الایgانوne. I other than "natural", or items 23a or 28a-f sho الایون میرود کامینانوی میرود الایون الایون الایون الایون الایون الایون الایون الایون الایون الایون الایون الای 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2X No Maryland Montgomery Derwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 17517 Wheatfall Drive 20855 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No Race - American Indian. 11. Marital Status other traumatic event, the Medical Examiner Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 2 Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: If Yes Give Specify: White Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Medical Secretary National Institutes of Health Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental and Mental permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic Haywood Collier Johnson Minnie Rice Forrest 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steven Chapman/Son 17517 Wheatfall Drive, Derwood, Maryland 20855 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) August 2, 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial Park <u> 2011</u> Rockville, Maryland Rockville, Inc. Signature of Funeral Service Licensee HOLON M01530 300 W. Montgomery Ave., Rockville, Maryland 20850 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Congestive Cardiomyopathy disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of Cause (Disease or linjury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Year Month Day Pregnant at time of death ate has been signed by the apage 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Chronic Obstructive Lung Disease 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 \(\sum \) Yes 2 \(\bar{X} \) No Other: မ 1 Inpatient 2 I ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🎇 Residence 6 ☐ Other (Specify) this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🛚 Natural 5 Pending work? 1 Yes 2 No Investigation 6 Could not be 2 Accident
3 Suicide
4 Homicide Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🟋 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) D20148 July 27, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 911 Russell Avenue, Gaithersburg, Maryland 20879 Steven Dolinsky,

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

JUL 2

32.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First Middle Last 2. Date of Death Physician/ Month aceres TRACIO 0550AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death Montgomery General Hospital Montgomery 01ney 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 X M 2 🗆 Days Hours August 13, 1940 Argentina 579-58-4995 70 Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at within 72 hours after death with the Maryland 10b Counts 10a. State 10c. City, Town or Location Director Maryland 1 Yes 2 X No Montgomery Silver Spring 10e. Street and Number 10g. Citizen of What Country? Funeral 2 Finsbury Park Court 20906 Argentina items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian Examiner Black, White, etc. "natural", or þ 1 Never Married 2 X Married Yes 2 X No Yes, Give Baltimore, Maryland 21215-0036 1 X Yes 2 □ No Specify: Argentinian 3 Widowed 4 Divorced Completed White Year or Dates I and 2 should be filed within 72 hours f Health and Mental Hygiene. item 27 is marked other than "natul other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) International College (1-4 or 5+) Elementary/Seconday (0-12) Systems Analyst Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Anibal Caceres Teresa Fernandez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr Graciela de Caceres / Wife 2 Finsbury Park Court, Silver Spring, Maryland 20906 20b. Place of Disposition (Name of cemetery crematory or other place)
Montgomery
Crematorium, Inc. 20a. Method of Disposition 20c. Location - City or Town, State ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 2011 Bethesda, Maryland 21. Signature of Funeral Service Licenses Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. Myclette Dan M01305 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part 1. Egyer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, of heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause, Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed and use as the burial-tran that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) Day 1 L Yes 2 L 9 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed this certificate has been 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? pade performed 1 ☐ Yes 2 ☐ No 2 🗹 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 잍 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 Natural (Month, Day, Year) 5 Pending injury 1 Yes 2 No Accident Investigation within 24 hours after death To the Funeral Director: 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Lecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2011

Registrar

Name and address of person who complete

2 9 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2011 24 64 11-05519 Jeffrey Bradford Dutton

emey bradio		1- For State Registrar		ate of Maryla	-	ertificate c		na Men		ZU I	11 2416
Physi Medical Exa			(First, Middl	e,Last) Bradf	ord		Dutton		2. Date of De Month July 24,	Day Year	3. Time of Death 0748 hrs
		4a. Facility Name (if		n, give street and nu	imber)		4b. City, Town, o	r Location o		4c. County of	Death
Funera	al	5. Social Security N		6. Sex	7. Age (In yrs.	last birthday)	Rockville	ar If Unde	r 24Hrs. 8. Date of I	Montgome	9. Birthplace (State or
Directo		552-88-4		1XM 2F	51	Yr	Months Day		A diam		Foreign Country) NY
any		Usual Residence of 10a. State	Decedent 10b. County		10c. City	y, Town or Loca	tion				10d. Inside City Limits
≱ '	3	MD		ntgomery			Bethesd	а			1 Yes 2 No
e Mary	Director	10e. Street and Num		1 Rd. Ap	+ 1/1	3M	10f. Zip Code	814		10g. Citizen of What	•
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 288-f she illiury or other frammitic group the Medical Premises.	Independent			12. Was Dec	edent Ever in U	J.S. 13. W	as Decedent of Hi	spanic Orig	in? (Specify Yes or N	United	American Indian, Black,
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11215-0036 Id be filed within 72 hours after fental Hygiene. Americal Phygiene.	Completed	Elementary/Secon	ndary (0-12)	College (1	-4 or 5+)		nost of working life	ı. DO NOT ı	use retired)		
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21215-0036 Juld be filed within 7 Mental Hygiene. marked other than	Re	David	- (D. J. F.)	Allen	Dut			Myra		ricia	Mellick
MD 2 id 2 shoul lith and N	2	I.		np(1ype,Print) n / Mother						mber, City or Town, Bethesda	
ore, I		20a. Method of Dispo	osition		20b.		sition (Name of ce		Date	20c. Location - Ci	
Baltimore, permit. Pages I ar Department of Hec Important: If ite		4 Donation 5	Other Spe	ecify:	Che		e Cremat		7/28/2011		sville, MD
Depa Impo		21. Signature of Fun	41	neum	M0038	'2 ²² k' 9	ame and Address app Fune 33 Gist	raT an Ave	nd Cremati Silver Sp	on Service	es 20910
Physiciar /Medica		23a. Part I. Enter the failure. List only	disease, or o	complications that ca	used the death	. Do not enter t	he mode of dying,	such as ca	rdiac or respiratory ar	rest, shock, or heart	Approximate Interval Between Onset and
Examine		Immediate Cause (Fi or condition resulting		a. Narcot:			toxicati	.on			Death
	_	Sequentially list cond		b					<u> </u>		
	Examiner	if any, leading to immosus. Enter Underl (Disease or injury that	ying Cause	Due to (or as a							
ecuted and - transit		events resulting in de	eath) Last	Due to (or as a d	consequence o	of):					
		X UNPENDED		AMENDED 2	3a,27,2	28a-f,p	er me,g91	8 8-3	-11 sm		
1876(Tificate ing physis as the b		23b. Was decedent pr	egnant in the	23c. If yes, o			tal death 3	Ectopic r	pregnancy	23d. Date of del Month	ivery Day Year
Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transi	Physician/	past 12 months?	9 Unkr		int at time of de	ath -	her (Specify)			Non.	Day Tour
	Phy (Part II. Other signific	ant condition			esulting in the u	inderlying cause g	iven in Part	I. 23e. Did t	obacco use contribut	e to the cause of death?
	ed by										Probably 4 Unknown
Division of Vital Records, lat or Attending Physician: The law require state death. a) Director: After this certificate has been sided in by the funeral director, page 2 should be	Completed				 -				24a. Was auto		e autopsy findings available to completion of cause of h2
ital Rec ician: The l certificate l	S	25. Was case referred	d to medical				26 Place	of Death (C			Yes 2 No
'Vita hysicia this ce	P B	examiner? 1 ✓ Yes 2	No	Hospital: 1 In	patient 2	ER/Outpatient		O.1.		Residence 6 🗸 0	ther: Scene
on of anding Ph th.	Ö	27, Manner of Death 1 Natural	5 Pendir		Day,Year)	28b. Time of Ir		yat Work? 'es 2 🔀 N	1	how injury occurred	
Visior Visior or Attend frer death. Sirector: in by the i	Certification:	2 Accident 3 Suicide	Investi	gation 28e Place		fd 7:45 ome, farm, stree	t, factory, office b				Rural Route Number, City
Spital ospital hours at meral I	Cert	4 Homicide	determ	ined (Specify)			less shel		Rockvil	le,Md.	
Division of Vital To the Hopital or Attending Physician: within 24 hours after death. To the Funeral Director: After this centif completely filled in by the funeral director.	Medical	(Check only	ertifying Phy edical Exam	iner: On the basis of	examination at	ge, death occur nd/or investigati	red at the time, da on, in my opinion,	te and place death occu	e, and due to the caus cred at the time, date	se(s) and manner as and place, and due to	stated. o the cause(s)
E 25 8	\ ₹	29b. Signature and titl		and manner sta)///	nost)	29c. License			29d. Date signed (
0		Julie	-14	lleng	ell	700	O.C.N	1.E.		July 25, 2011	
-		30. Name and address Victor Weedn		•	,	,	. Baltimore St	reet, Bal	timore, MD 2122	23	
S Regis	tate	31. July illed Month 2 9 2	Pay Year)	22. Regi	istrar's Signatu	re					

11-05351 Ivary Doles Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 20 | 1 | 24 | 65

·		1- For State Certificate of Death Reg. No.	2011 2410	<i>y</i>
Physicia	ın/	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day	3. Time of Death	
Medical Exami	ner	I Ivary Doles July 18, 2011	0800 hrs	
		1103 North Stockton Street Baltimore		
Funeral Director		Months Days Hours Min	O/YYYY) 9. Birthplace (State or Foreign	
Director		579-50-4445 1 M 2XF 73 Yrs. Oct. 2, 193	37 Wash.,DC	
rey		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Lim	nits
nd show	٦	, MD Baltimore	1 XYes 2	No
Aaryland 28a-f show any 1 at once.	Director	10e. Street and Number 10f. Zip Code 10g. Citizen	n of What Country?	_
h the days	흐	1103 North Stockton Street 21217 Un	nited States	
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f sho rother traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	l. Race - American Indian, Black, White, etc.	
her de		1 3 Widowed 4 XIDivarced III Yes, Give Yest 1 1 Yes 2M No coordy:	pecify: Black	
ours af etural	d b	1 or Dates:	d of Business/Industry	
1215-0036 d be filed within 72 hours after fontal Hygiene. narked other than "natural", event, the Medical Examiner	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use retired)		
5-003 led withii Hygiene. other th	ĕ	4	Govt.	
21215-0036 and be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be C		mane)	
2121 ould be fi I Mental I s marked	P		or Town, State, Zip Code)	
e, MD 1 and 2 sho Health and item 27 is		Jennifer Dikes/niece Brooklyn, NY 1/201		j
ages 1 and nt of Health it: If item other trau		1 Burial 2 K Cremation 3 Removal from State crematory or other place) 7/23/11	cation - City or Town, State	
Baltimore, permit. Pages I as Department of He Important: If ite		4 Donation 5 Other Specify: Riverdale Park Crematory Riv	verdale,Md	
Baltimore permit. Pages 1 Department of F Important: If injury or other	1	22. Name and Address of Facility Hodges & Edw 3910 Silver Hill Rd., Sui	ards F.H. tland.MD 2074	.6
Physician	\neg	254. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock,	, or heart Approximate Interv	val
/Medical Examiner	ŀ	failure. List only one cause on each line. Immediate Cause (Final disease a. Hypertensive Cardiovascular Disease	Between Onset ar Death	10
A		or condition resulting in death) Due to (or as a consequence of):		
	Je.	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):		_
	Examiner	c. (Disease or injury that initiated Levents resulting in feath Last Due to (or as a consequence of):		_
cuted nd transit	ă	events resulting in death) Last Due to (or as a consequence or): d.		
760, cate be executed physician and the burial - transit	Medical	☐ UNPENDED ☐ AMENDED		
760 ficate b g physic s the bu			Date of delivery	
Box 687 s death certific the attending I ed for use as th	iciai	past 12 months? The Dirth 2 Fetal death 3 Ectopic pregnancy Molecular	Milli Day real	
that the death ned by the att detached for	Physician	1 Yes 2 No 9 Unknown 9 Unknown		
of Vital Records, P.O. Box 68760, ng Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and uneral director, page 2 should be deacched for use as the burial—transi			contribute to the cause of death?	n
cords, aw require nas been si 2 should b	Completed by	24a. Was an 2	24b. Were autopsy findings availab	
of Vital Records, ng Physician: The law require ther this certificate has been si meral director, page 2 should b	립	autopsy performed?	prior to completion of cause of death?	f
tal Rec			1 Yes 2 No	_
Vital ysician:	o Be	examiner? Hospital: Hospital	e 6 🗸 Other: Scene	
n of ling Ph	謯	27 Manner of Death 28a Date of Injury 28h Time of Injury 28c Injury at Work? 28d Describe how injury of	occurred	
the eath	뼕	2 Accident Investigation 1 Yes 2 No		
Division pital or Attendu ours after death.	Certification:	3 Suicide 6 Could not be determined control of the determined determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Nor Town, State)	Number or Rural Route Number, Ci	ty
the Hospital hin 24 hours at the Funeral appletely filled		1/98 Centiler	nanner as stated	_
Di To the Hospital within 24 hours a To the Funeral I completely filled	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and manner stated.		
FSFS	Ž∣		e signed (Month, Day, Year)	
0		(July 20), 2011	
(30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223		
St	ate		*	
Regist				

Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and ately filled in by the funeral director, page 2 should be detached for use as the build - transit within 24 hours a

To the Funeral I

completely filled

Medical

State Registrar Date filed (Month, Day, 32. Registrar's Signature

and manner stated

ee.

OCME

30. Name and address of person who completed cause of death (Item 23a)

determined

4 Homicide 29a. Certifier 1

29b Signature and title of certific

Victor Weedn MD JD

CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

July 23, 2011

(Specify) Single Family Home

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Fer FH G918 8/04 20111 Jh
State of Maryland / Department of Health and Mental Hygiene 2 0 1 1 for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 70 Month Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** COMMUNI 24 Hrs. Min. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 ☑ M 2 ☐ F Months Days Hours Nov. 5. Country) **Director** Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State **Funeral Director** Baltimore 1 ☑ Yes 2 ☐ No DM 10g. Citizen of What Country? 5 10e. Street and Number items 23a USP. 12. Was Decedent Ever in U.S. Armed orces? 1 Nes 2 □ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 10 Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 3 Widowed 4 Divorced "natural" 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO 1001 use retired) (Specify only highest grade completed) h and Mental Hygiene. 7 is marked other than "r traumatic event, the Med ay (0-12) College (1-4 or 5+) lailor Be item 27 or other 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory of other Department of H Important: If ite any injury or ot once. 1 Burial 2 Cremation 3 Removal from State -201 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between ret and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) physician and the burial-transit Cause (Disease or liniury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has 1 ☐ Yes 2 ☐ No Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Hospital: Other: 2 X No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Director: After that in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	of Maryland		rtment of H tificate of L		Mental Hygie		24168
			1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medio		James Driscoll	F1	anagan				26, 2011	9:20 A M
1	Examin		4a. Facility Name (If not institution, give street and r	number)		4b. City, Town, or	Location of Death		4c. County of Death	
			4011 Chaney Cove Ct.			Dunk			Calve	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. Ia		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	ear) 9. Birth	place (State or Foreign intry)_
	Director		5/8-34-19/1	82	Yrs.			Feb. 15,	1929 Net	w Jersey
	and and		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	Mary f sho	ភ្ជ	MD Calvert			Dunl	kirk			1 ☐ Yes 2 🛣 No
	28e	rect	10e. Street and Number			10f. Zip Code		10g	. Citizen of What Cou	intry?
	3a or	Funeral Director	4011 Chaney Cove Ct.			2	20754		United St	ates
	death ms 2	era	11. Marital Status 12. Was De	ecedent Ever in U.S	S. 13. \	Vas Decedent of Hi f Yes, specify Cuba	spanic Origin? (S	pecify Yes or No-	14. Race - Ameri	
ဖ	after or ite	Ē		Forces? 5 2 □ No Give 10/6		r ves, speciny Cuba I□ Yes 21X No	Specify:	o nican, etc.)	Black, White	
<u> </u>	filed within 72 hours after death with the Maryland Hygiane. bther than "naturel; or items 23a or 28e-f show ant, the Morcal Examiner must be mailled at	d by	3 Widowed 4 Divorced Year or	Dates: 1946-	48	10 163 244140	Specify.		Зреспу.	White
با م	72 h	Completed	15. Decedent's Education (Specify only highest grade completed	d)	(Give	lent's Usual Occupa kind of work done of	luring most of wor	king 16	b. Kind of Business/li	ndustry
2	within ne. han	m Id	Elementary/Secondary (0-12) College	(1-4or 5+)		neer)		Aero-spac	e
7	iled v dygie ther t		17. Father's Name (First, Middle, Last)		Eligi	neer	18 Mother's Nan	ne (First, Middle, Ma		
au	d be intal line of order	Be C	Edward J.	Flanag	an		Vera	(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	O'Brien	
Maryland 21215-0036	should Me mark matic	은	19a. Informant's Name/Relationship (Type, Print)			g Address (Street a	and Number or Ru	ral Route Number, C	City or Town, State, Zi	ip Code)
E S	alth ar 1th ar 27 Is r treu		Theresa C. Flanagan /	Wife	4011	Chaney Co	ove Ct.,	Dunkirk,	MD 20754	
ē,	s 1 ar f Hea item othe		20a. Method of Disposition	CO	ace of Dispo	sition (Name of natory or other place	e)	Date 20	c. Location - City or T	own, State
Ê	Page lent o nt: If ry or		1 ☐ Burial 2 【Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)			e Cremate		27/2011	Beltsvill	e, MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mendal Hygiene. Department of Health and Mendal Hygiene. Importent: If item 27 is marked other than "naturel; or items 23a or 28e-1 show emportent: If item 27 is marked other than "naturel; or items 23a or 28e-1 show empirient or in items and the naturel at any injury or other treumatic event, the Marcal Examinet must be natured at once.		21. Signature of Euneral Service Licensee		NAME AND ADDRESS OF TAXABLE PARTY.	-		remation S		
m	8 0 E 8 0	0.0	1) Problem		93	3 Gist A	ve., Sil	ver Spring	3, MD 20	910
			23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause or	t caused the death n each line.	. Do not ent	er the mode of dying	g, such as cardiac	or respiratory arrest		Approximate Interval Between
, i	Pnysician	i n	Immediate Cause (Final disease or condition	prelar	al V	Ascula	2 Acc	don	71	Onset and Death
	/Medical Examiner		resulting in death) Due t	o (or as a consequ		101		1.		201
	Lxammer	_	Sequentially list conditions, b.	o (or as a consequ	2/126	59 Chat	enosci	esope	DISPUSE	2
	led Isit	Examiner	if any, leading to immediate Due to cause. Enter Underlying Cause (Disease or injury	o (oi as a consequ	ierice or).					
	axecu al-tra	xar	that initiated events c	o (or as a consequ	ience of):					
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical	U ,							
68	ifficat ig phy as th	0								
Вох	h cer endin	Z/N	23b. was decedent pregnant	outcome of pregnar		Ectopic pregnancy			23d. Date of deliv	,
m m	deat e attr	sicia	In the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Light	gnant at time of de		Other (specify)			Month	Day Year
Q.	at the i by th stach	hy	9 Unknown					on Didash		the server of death?
ŝ	w requires that the death certific been signed by the attending f should be detached for use as	Completed by Physician/M	Part II. Other significant conditions contributing to	1000		nderlying cause give	en in Part I.		cco use contribute to 2 □ No 3 1 Pro	bably 4 Unknown
ord	requir een s nould	ted	Covorand Dr tere	1 0120	se_			1 105	2 140 3/35,10	— — — — — — — — — — — — — — — — — — —
e C	law lasb	ple	HOVE STENOSI	<u>S, </u>				24a. Was an autopsy	prior to c	opsy findings available ompletion of cause of
	: The cate I	ပ္ပ	atrial Fibrille	<u>zton</u>				performe 1 ☐ Yes 2	No 1 ☐ Yes	2□ No
	icien sertifi ector	Be	25. Was case referred to medical examiner? Hospital:	-		t 2 DOA Othe	ST-WOOTS TOWNS IN	th (Check only one)	_	_
o	Phys this ral dir	2	1 Tes 2 No		ER/Outpatier 28b. Time of	I 3 DOA	4 🗀 Nursing F	ome 5 X Resident 28d. Describe how	ce 6 Other (Spec	ify)
U	ding h. After funer	tion	1 Natural 5 Pending (Me	onth, Day Year)	Injury	Worl	k? Yes 2 □ No	ESG. BOSONEO NOV	injury cocomoc	
Division of	Attendi death. ctor: A y the fu	fica	3 Suicide 6 Could not be 28e. Pla	ce of Injury - At ho				28f. Location (Stre	et and Number or Ru	ral Route Number,
2	after after Dire	Certification:	4 Homicide determined bui	lding, etc. (Specify	")			City or Town,	State)	
	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier 1 Certifying Physician: To the (Check only 2 Medical Examiner: On the							
	the H in 24 the Fi	Medical	one) and m	anner stated.						
	Vilt To COM	2	29b. Signature and title of certifier	1 , 1		29c. Licenso	a numoer	290	d. Date signed (Month	, Day, Tear)
7	. 1		Kay UV blo	le VV		DI	7324		1/26/20	>1[
(00,		30. Name and address person who completed ca		23a) (Type,		100	D .	- Fml	CIMI
	- 01-		1000	. Registrar's Signat		Nevrim	ac U	TVINCE	- LAGU	NAI
	Sta Registi		JUL 2 9 2011 Beneva	A. Jack	Par de					

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			For State	State	of Ma	aryland		irtment <i>tificate</i>			and M	ental Hy	giene Reg. No.	201	1	24	169
			Registrar 1. Decedent's Name (First, I	Middle, Last)			007	inreate	0,0	Catin	Т	2. Date of Dea				3. Time of I	Death
	Physicia Medic		Mel	ville T.	Fost	er,	Jr.					July	27	201	1	11:4	5 P ^M
	Examin		4a. Facility Name (if not insti Gilchrist	itution, give street and r	number)				own, or WSON	Location o	f Death			County of D altimo			
	Funeral Director		5. Social Security Number 216-28-3881	6. Sex 1 X M 2		79 (In yrs. Ia	st birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours		8. Date of Birt (Month Da April		1932		ace (State or \mathbf{y}) 1 and	
			Usual Residence of Decede		-	10a City	Town or Loc	nation				110111				ld. Inside City	
	aryland a-f sh fied a	ecto		ltimore		Tow		ation								1 \(\sum \) Yes	
	the M or 28	ä	10e. Street and Number					10f. Zip					109. Citi	zen of What		ry?	
	th with ms 23; must I	Funeral Director		igh Circle			140.11		1204		1-0.0	75 . 1/2 N -	Т		SA —		
036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status1 ☐ Never Married 2 X3 ☐ Widowed 4 ☐ Div	Married 1 🛣 Y	Forces?		lf	Vas Decede Yes, speci	fy Cubar	n, Mexican	in? (Spec , Puerto F	ify Yes or No- lican, etc.)		14. Race - A Black, W Specify:		tc.	i
2-0	2 hour "natu	plet		ecedent's Education highest grade complete	ted)		16a. Deced	ind of work	done de	ation uring most	of workin	g	16b. Ki	nd of Busine	ss Indi	ustry	
121	vithin 7 iene. r than	Completed	Elementary/Seconday (0		e (1-4 or 5 +4	+)		NOT use untar					Exx	on			
pu	filed wall Hyg d othe	o Be	17. Father's Name (First, Mid							18. Mothe		(First, Middle,		Surname)			
<u> </u>	uid be d Ment marke natic e	70	Melville T. 19a. Informant's Name/Rela		r.					Grac		utchins		T 01.1	7: 0		
Ma	d 2 shoalth an 27 is r traul	ı	Jacqueline H		Wife			-				Route Numbe Γ OWSON,	-			ide)	
Baltimore, Maryland 21215-0036	e 1 and of Hea If item or othe		20a. Method of Disposition	nation 3 Removal fi		CE	ace of Disposemetery, crem	sition (Nam	e of her place	9)	D	ate	20c. Lo	cation - City	or Tov	vn, State	
Iţi	it. Pagi intment intant: njury c		4 Donation 5 0	ther (Specify)	1	Hil	ltop S				- 29 - :			vson,	MD.		
Ba	perm Depa Impo any i			116/				- 1()5() ·	York	Ka.	neral H Towson	, UID.	Inc. 2120	4		
			23a. Part 1. Enter the dises shock, or heart failure	ase, or complications th . List only one cause or	at caused	the death	. Do not ente	r the mode	of dying	, such as	cardiac or	respiratory an	rest,			Approximate Interval Bety	veen
¢ .	Ph _{sician/} Medical		Immediate Cause (Final disease or condition resulting in death)	a. B	20	a consequ	Jus	four							+	Onset and D	eath
	Examiner		Commentation like the conditions		to (or as a	a consequ	ence or).										
Λ	p iii	Examiner	Sequentially list conditions if any, leading to immediate Enter Inderlying	e Due	to (or as a	a consequ	ence of):										
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	OH		30. Name and address of p	erson who completed o	cause of d	eath (Item	23a) (Type. F	_	7 00 i	150	7	l	<u>d</u> :	2011		911	204
	19,		Philip SI	iahrelu,	670	N.	Clear	Res !	the	eet.	Suit	2 410	5,3	altre	ul	wig	7
	Sta Registra		31. Date filed (Month, Day, JUL 29 201	Year)	2. Registra	ar's Signat	ure			•							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Susan X. Fan July 2011 5:00 A. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 6 Buckley Court Towson Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) 1 🗆 M 2 🛣 F Days January 28, 1937 527-93-2392 74 **Director** China Usual Residence of Decedent ian "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Towson 1 Yes 2XXNo 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? United States of America Funeral 6 Buckley Court 21286 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2XX Married Yes 2XXNo Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: Chinese 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na
any injury or other traumatic event, the Medic 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Engineer Engineering Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ unk. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Chihsing Fan/ husband 6 Buckley Court Towson, Maryland 21286 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State July 28, cemetery, crematory or other place) Evans Funeral Chapel – Bel Air 1 Burial 2XXCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2011 Forest Hill, Maryland 21. Signature Fureral Service Li Peaceful Alternatives Funeral and Cremation Center, P.A. 2325 York Road Timonium, Maryland 21093 23a. Port 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Metustan disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or linjury and that initiated events resulting in death) Last burial-trar Due to (or as a consequence of): attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the burn Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregna 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 mont Day Pregnant at time of death g Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 🗆 🗚 0 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗌 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 1 Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🛛 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 5 Pending work? 2 🗆 No 2 Accident
3 Suicide М Investigation 1 Yes Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier SW 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thede 31. Date filed (Month, Day, Year)_ gistrar's Signature State Registrar

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11-05303 Richard Flynn

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ilouiour Exulli		4a. Facility Name (if not institution	on, give street and number)		4b.	City, Town, o	r Location of De	July 16,		ounty of Death		
,		University Hospital Baltimore										
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		U-~UL				O.C.I	M.E.		July 17	′, 2011		
		 Name and address of person Donna M. Vincenti, MD 				. Baltimore	Street, Balt	imore. MD 21	1223			
St	ate	31. Date filed (Month 1997, Year)			0		330t, Dait					
Regist	rar	JUL 2 9	2017 Sener	U 2	1. beer	4						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 26^{Day} Physician/ JULY 9:00 A. M 201 gar Cynthia Goquen Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Forest Hill 104 Gwen Drive Unite G Social Security Number If Under 1 Year If Under 24 Hrs. Date of Day, Ye (Month, Day, Ye . Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F 1937 Rhode Island Director Sept. 038-22-8700 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 X No Forest Hill Maryland Harford 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Funeral 23a 21050 104 Gwen Drive Unit G United States permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Armed Force: If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ģ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 White 1 Yes 2XXNo Specify: If Yes, Give 3 Widowed 4 X Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Special Education Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Emery Wood Ann Saucier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathryn Harclerode / Daughter 104 Gwen Drive Unit G Forest Hill, MD 21050 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1
Burial 2
Cremation 3
Removal from State Evans Funeral chapel Forest Hill, Maryland 4 Donation 5 Other (Specify) Bel Air 21. Si pra ure of Funeral Service Licensee Evans Funeral Chapel & Cremation Service-BelAir tusto 3 Newport Drive Forest Hill, Maryland 21050 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Breast Physician (ange disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an autopsy perform certificate director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 🗹 Residence 6 🗌 Other (Specify) 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA After this c 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred 5 \square Pending 1 Natural injury 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation Funeral Director 6 🗆 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a To the Funeral C Medical 29a. Certifier 🔏 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Registrar DHMH 17 Rev 7/2009

gr

State

(Check

only o 29b. Signat

Name a

of certifier

9

person who completed cause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

critifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of I	Maryla					nd M	lental Hy	gien	е			
		Registrar 1. Decedent's Name (First, Middle, Las	t)	Certificate of Death						2. Date of Death			-	24174		
Physician/ Medical Jean M. Dorsey Gran						ı†					Month		2011	'ear	3. Hime of Death 10:50 A M	
yer .	Examir		4a. Facility Name (if not institution, give	street and number	7)			-	Location of		041) 2	_	c. County of	Death	10.50 A	
-	1			ngton Medical Cntr.			Glen Burnie						nne Aı	rund	el	
	Funeral Director		5. Social Security Number 6. Se 212-30-1107	×	Age (In yrs. 77	last birthday) Yrs.	Month	er 1 Year B Days	If Under 24 Hours	4 Hrs. Min.	8. Date of Bird 08-30-	th 193	3	9. Birthp Coun	place (State or Foreign try) MD	
	nd how at	٦	Usual Residence of Decedent 10a. State 10b. County		10c, C	ity, Town or Loc	ation						_	1	0d. Inside City Limits	
	farylar 3a-f s tified	Funeral Director	MD Anne Aru	ndel		,		.Te	essup					I.	1 Yes 2 X No	
	the M	٥	10e. Street and Number	Idel			10f. Z	ip Code	Боопр			10g. C	itizen of Wh	at Coun	try?	
	n with	nera	7533 Montevideo	Court				2	20794				United	l St	ates	
	r item	II.	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Deceder Armed Forces	3?	.S. 13. V	Vas Dec Yes, sp	edent of Hi	spanic Origir n, Mexican, F	n? (Spec Puerto F	cify Yes or No- Rican, etc.)		14. Race -	Americ White, 6		
Baltimore, Maryland 21215-0036	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Heath and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	ed by	3 M Widowed 4 □ Divorced	1 Yes 2 If Yes, Give Year or Dates		1	☐ Yes	2 x No	Specify:				Specify:		hite	
5-0	2 hour	plet	15. Decedent's Ed (Specify only highest gra			16a. Deced	ent's Us	ual Occupa	ation uring most o	of workin	19	16b.	Kind of Busi			
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lan	should and is ma		19a. Informant's Name/Relationship (Ty	oe, Print)		19b. Mailin	g Addre	ss (Street a			Route Numbe				ode)	
,e	1 and 2 s of Health item 27 i		John D. Grant - s	son					eo Cou	rt,	Jessup	, M	arylar	1d 2	0794	
nor	permit. Page 1 a Department of I Important: If its any injury or of		20a. Method of Disposition 1XX Burial 2 Cremation 3		te	Place of Dispos cemetery, crem	atory or	other place	· !		ate		_ocation - Ci	•	,	
iţi	nit. Pa artme ortan injun		4 ☐ Donation 5 ☐ Other (Specify 21. Signatur of Funeral Service License		Mea	adowrid	ge N	lem. I	ark 0	7-30)-2011	E11	kridge	, M	aryland 1 Home at	
B	permit Depar Impor any in		Mark H.B	olaun											т ноше ат MD 21075	
	Physician/		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or Immediate Cause (Final disease or condition	lications that caus e cause on each I	ed the dea ine.	th. Do not ente	the mo	de of dying	, such as ca	ardiac or	respiratory arr	est,			Approximate Interval Between Onset and Death	
- Samuel	Medical Examiner		resulting in death)	a. Tue to (or a	s a consec	uence of):	14	4710	ua							
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MA	rate be executed physician and the burial-transit	al E	resulting in death) Last	Due to (or a	s a conseq	uence of):										
200	physic physic the b	edical		d										+		
.89	certific nding use as	n/M	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcom	e of pregna	ancy				-			23d. Date of	of delive	n/	
Box 68	requires that the death certific been signed by the attending should be detached for use as	Completed by Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live Birtl 4 ☐ Pregnant 9 ☐ Unknow	at time of	al death 3 🗌 death 5 🗍	Other (/				Month		Day Year	
P.0	that th	y Ph	Part II. Other significant conditions co	ntributing to death	but not re	sulting in the ur	dertying	cause give	en in Part I.		23e. Did to	bacco	use contribu	te to the	e cause of death?	
* Subject of Suzuri Chrodis								1 ☐ Yes 2 S No 3 ☐					ably 4 🗆 Unknown			
COL	aw rec as bee 2 sho	plei	O								24a. Was a			ere autopsy findings available for to completion of cause of		
Re	ding Physician: The la h. After this certificate ha funeral director, page	Con										rmed?	dea	th?	2 ¥ îNo	
ta	ician: Sertific ector,	Be	25. Was case referred to medical examiner?	lospital:					ce of Death ((Check o	only one)					
Į V	Phys	한 :	1 ☐ Yes 2 ☑No 27. Manner of Death	1 Ninpa		ER/Outpatient 28b. Time of	3 🗆 0	Other 28c. Injury	4 L Nursi		ne 5 🗆 Resid			Specify)		
ouo	ath. r: Afte re fune	icate	1 Natural 5 Pending 2 Accident Investigation	(Month, D	injury wor		work?			od. Describe no	ribe how injury occurred					
Division of Vital Records, P.O.	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending is completed filled in by the funeral director, page 2 should be detached for use as	l Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, street, factory, o building, etc. (Specify)					tory, office 28f. Location (Street and Number or Rura City or Town, State)					r Rural i	Route Number,		
	ne Hospit n 24 hour ne Funera	Medical	29a. Certifier 1 Certifying Physical Check 2 Medical Examination only one) 3 Certifying Nurse	er: On the basis of	examinatio	n and/or investig	ration ir	my oninior	death occur	irrad at th	ha tima data ar	nd place	and due to	the caus	co/c) and manner stated	
	To the vithing complete comple		29b. Signature and title of certifier					c. License	number	_			te signed (M			
			Selle 1	ND			1	38	158			07	1/23	120	711	
	10		30. Name and address of person who co Duliet Sinch	empleted dayse of	death (Iten	1 23a) (Type, Pr	Has	Lwa	y Sú	0	Plen 1	Bur	me.	10/	02061	
	Stat Registra		31. Day 2 2 9, 20 (*)	32. Regis	ar's Sic	arks		1								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ha Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner th more 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 F Months Hours Min Director Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10b. County aţ 10c. City, Town or Location Director Examiner must be notified 1 Yes 2 No more 5 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a items Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 5 δ 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural", 3 ₩idowed 4 □ Divorced Completed permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First Middle, Maiden Surname) မ arnes OVNEY 9a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, Cit. or Town, State, Zip Code) Road Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) taltimore 21. Signal re f Funeral Service Licenses 22 Home, 23a. Part . Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition resulting in death) Medical as a consequence of Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Examir sician and burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d, Date of delivery Live Birth 2 Fetal death 3 Fctopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 5 Other (specify) Pregnant at time of death signed by the a Id be detached f Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed Yes 2 No this certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Tes Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After a completed filled in by the funer Natural Accident 5 Pending 1 🗌 Yes 2 🗌 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Descripting Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BAL Q 31. Date filed (Month State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 1 per doc g918 8-8-11 yr.
State of Maryland? Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Theodore de la Ree Hopper Year **Physician** Month Theodore de la Ree Hooper 1:20AM 2011 0 Juli /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Arnold Future Care Chesapeake If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 9. Birthplace (State or Foreign Country) New Jersey 5. Social Security Number 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) July 18, 19 Months 1 X M 2 □ F 1922 Director 88 163-20-5069 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show Pages 1 and 2 should be filed within 72 hours after death war frie Maryla nent of Health and Mental Hyglene.

ant; if Hean 27 Is marked other than "natural", or Items 23a or 28a-f show ant; if them 27 Is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, it is hadical Examinate must be notified at 1 □Yes 2 No Severna Park Director MD Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21146 USA 7 Sunset Dr. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian. Black, White, etc. 1 Never Married 2 Married white 1 □Yes 2 No Specify: 2 3 XWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry un 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) chemist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Isaac Bogart Hopper Martha de la Ree ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lee Hopper Laque - daughter 19 Admiral Rd; Severna Park, Maryland 21146 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Pages 1 Department of H Important: If Ite any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4X Donation 5 Other (Specify) 21. Signature of Funeral School 22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore St; Baltimore, MD 21201 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Myclodysplasti /Medical Due to (or as a consequence of Examiner Sequentially list conditions, Examine Due to for as a consequence off cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-tran Due to (or as a consequence of): physician Physician/Medical the as attending p IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Yea 5 Other (specify) signed by the a 1 TYAS 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed neec Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy perform 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: AUNursing Home 5 Residence 6 Other (Specify) Hospital: al or Attending Physis after death.
It Director: After this code in by the funeral dire 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled e Funeral 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) To the I 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar

Baltimore, Maryland 21215-0036

death certificate be execu

Box 68760,

P.0.

of Vital Records,

Division

Physiclan:

Hospital

DHMH 17 Rev 1/2001

back

M.D.

32.

8601 Veterans Registrar's Signature

30. Name and address of per townho completed cause of death (Item 23a) (Type, Print)

Nes

31. Date filed (Month, Day, Yeld)

D57531

Suite 204 Melleroule

(uly 04, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month JULY 2011 HAUF 5:10 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FOREST HILL HARFORD FOREST HILL HEALTH & REHAB CENTER Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 M 2XXF Days Hours Min. Balt. Maryland 100 Yrs March 17 **Director** 220-14-5594 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Forest Hill Harford Maryland 1 ☐ Yes 2 🛣 No 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? United States 21050 204 Kimary Court Unit 3D of America 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes 2XXNo Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: white Completed 3 X Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Bendix Assembler Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Anna Bell Charles Bell 19a. Informant's Name/Relationship (Type, Print)
Patricia Saffran/ daughter 21050 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 204 Kimary Ct. Unit 3D Forest Hill, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Evans Funetral Chapel-Bel Air 1 Burial 2 Kircremation 3 Removal from State 4 Donation 5 Other (Specify) Forest Hill, Maryland Peaceful Alternatives Funeral & Cremation Center, P.A. 2325 York Road Timmium, Mayland 21093 21. Signature of Foneral Service Licensee 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ orcard disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a conseduct the attending physician and hed for use as the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No should be detached 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed? Yes 2 V No 2 🗌 No 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 No 1 Yes ပ 1 Inpatient 2 ER/Outpatient 3 DOA

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and P.O. Box 68760 Records, Division of Vital

To the Funeral Director: After this certific completed filled in by the funeral director,

Certificate:

27. Manner of Death

Natural Accident

3 Suicide 4 Homicide

gb. Signature and title of certifier

29a. Certifier

5 Pending

Investigation

determined

6 Could not be

Medical

State Registrar DAVID MCCLURE 615 W. MACPHAIL ROAD

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28c. Injury at

1 Tes

2 🗌 No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BEL AIR

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

MD. 21014

28d. Describe how injury occurred

31. Date filed (Month, Day, Year)

28a. Date of injury (Month, Day, Year)

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death July 26, 2011 David Lyle Hilborn

4b. City, Town, or Location of Death

3:11 A M

4c. County of Death

Physician/ Medical Examiner

For State Registrar

4a. Facility Name (if not institution, give street and number)

Funeral Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Physician/ Medical **Examiner**

attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page

pivision of Vital Records, P.O. Box 68760

	Holy Cross Hospit	Silver Spring					Montgomery						
	5. Social Security Number 6. S	ex 7	. Age (In yrs. la	st birthday)	If Under 1 Y		er 24 Hrs. Min.	8. Date of Bir	th	9. 1	Birthplace (State or Foreign		
	305-30-2421	⊠ M 2 □ F	87	Yrs.	Months D	ays Hours	IVIIII.	May 28	9:	24 (C	anada		
1	Usual Residence of Decedent		<u> </u>						•				
<u>_</u>	10a. State 10b. County		10c. City	, Town or Loc	cation						10d. Inside City Limits		
뜅							,				1 ☐ Yes 2X No		
<u>e</u>	Maryland Montgom	ery			Burt	onsvil	те				T L Tes 244 NO		
91	10e. Street and Number	Street and Number 10f. Zip Code 10g. Citizen of W 1953 Carthage Circle 20866 United											
ar	13053 Carthago Ci												
Š		Marital Status 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-											
٤	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No									Black, W			
9		1 ☐ Yes 2 If Yes, Give	2 X J No	1	1 ☐ Yes 2 🕱 No Specify:					Specify:	·		
Ę	3 Widowed 4 Divorced	Year or Date	es.						,	White			
용	15. Decedent's E (Specify only highest gr				16a. Decedent's Usual Occupation (Give kind of work done during most of working) 16l						6b. Kind of Business Industry		
Ĕ	Elementary/Seconday (0-12)	College (1-4	or 5+)	life. DO NOT use retired)									
ŏ		5+		Teach	ner		E	Education					
Be Completed by Funeral Director	17. Father's Name (First, Middle, Last)					18. Mo	ther's Name	e (First, Middle,	Maiden S	urname)			
욘	- 01 1 7717	1								,			
	James Stanley Hil							geman					
	19a. Informant's Name/Relationship (7)	ype, Print)		1.0	_			l Route Numbe					
	Gloria A. Zapata	/ Daught	ter	1395	3 Cart	hage C	ircle	Burtor	nsvil	le, M	20866		
	20a. Method of Disposition		20b. P	ace of Dispo	sition (Name o	f		Date	20c. Lo	cation - City	or Town, State		
	1 🔲 Burial 2 🔀 Cremation 3 🗆				natory or other		7/20	/2011	7.7	محدث مالات	Mare Franci		
	4 Donation 5 Other (Special				ney Cre						Maryland		
- 1	21. Signature of Funeral Service Licens	e /	1/2	C22	Name and A	ddress of Fac	matic	n Servi	ice P	.O. Bo	ox 784		
	Deverly & H	servon	MO1	251 Be	everly	L. Hec	krott	e, P.A.	Cla	rksvi.	ox 784 Lle, MD 21029		
	23a. Part 1. Enter the disease, or com	plications that ca	used the death								Approximate		
	shock, or heart failure. List only o										Interval Between Onset and Death		
	disease or condition Acute Respiratory Failure												
	resulting in death) a. Due to (or as a consequence of):												
	Sequentially list conditions. b. Sepsis												
je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or ilinjury At leithed where the disease or ilinjury The second of the condition of the condi												
直													
ха	that initiated events resulting in death) Last	Ų. -	r as a consequ	ence off:							 		
=	resulting in death) Last	200 10 (0)	. as a sonocqu	01100 017.									
i Si		d											
by Physician/Medical Examiner								_					
2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	ome of pregnal	ncy	7				1 2	23d. Date of	delivery		
cia	in the past 12 months?		irth 2 🗌 Feta ant at time of d		□ Ectopic preg □ Other (speci					Month	Day Year		
sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	g Unkno		Catil OL	_ Other (spee)	<i>)</i> /							
Ph			-4h h4			e siyon in Da	+ I	00 Di 14			1 11 C 1		
by	Part II. Other significant conditions of	ontributing to dea	atri Dut Hot 1651	aiting in the t	indenying caus	se giveri ili ra	11.				to the cause of death?		
								1 🗆	Yes 2	□No 3□	Probably 4 🛭 Unknown		
Completed								24a. Was	an	24b. Were	autopsy findings available		
ᇤ								auto		prior death	to completion of cause of		
ပ္ပ								1 🗆 Yes	2 🔀 No		Yes 2 No		
36	25. Was case referred to medical examiner?				2	6. Place of D	eath <i>(Checl</i>	k only one)					
0	1 ☐ Yes 2 🔀 No	Hospital: 1 X Ir	npatient 2	ER/Outpatier	nt 3 🗆 DOA	Other: 4 \square	Nursina Ha	me 5 🗆 Resi	dence 6	Other (St	pecify)		
	27. Manner of Death	28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred											
cat	1 X Natural 5 ☐ Pending 2 ☐ Accident Investigation		, Day, Year)	injury	work? M 1 Yes 2 No								
Ě	3 Suicide 6 Could not be	ne l	28e. Place of Injury - At home, farm, stre					206 1	Location (Street and Number or Rural Route Number,				
er	4 Homicide determined		g, etc. <i>(Specify,</i>		eet, lactory, of	ille		28f. Location (City or Tov		wumber or	riurai Houte ivumber,		
alc													
Jic	29a. Certifier 1 X Certifying Phy												
Medical Certificate: To Be	(Check 2 ☐ Medical Exam only one) 3 ☐ Certifying Nur										ne cause(s) and manner stated. as stated.		
-	29b. Signature and title of certifier			-5-1		ense numbe					nth, Day, Year)		
	M	4 0								July 26, 2011			
	Both	my,				8096			Jul	y 26,	2011		
	30. Name and address of person who	completed cause	of death (Item	23a) (Type, F	Print)								
	Satvam Shah 150	0 Forest	Glen I	iz bs	lver Sr	rina	MD 20	0910					

State Registrar 31. Date filed (Month, Day, Year)

Please Type of Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Month Medical 4a. Facility Name (if not institution, give street and n 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Sex 1 M 2 □ F Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign County) Maryland **Funeral** Aug Pay, Year 59 Min. Months Hours **Director** 215-76-1746 51 Usual Residence of Decedent : If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 Yes 2 No Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21218 3900 Loch Raven Blvd USA 11. Marital Status - unk Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1 Yes 2 No 1977 -Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white If Yes, Give 1978 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation UNK (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry unk 15. Decedent's Education (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Joseph Hartman Nancy Ritter permit. Page 1 and 2 should Department of Health and M Important: If item 27 is man any injury or other traumat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3620 Second St; Brooklyn, Maryland 21225 Skip Ritter - uncle 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) in State cemetery, crematory or other place) 22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore St; Baltimore, MD 21201 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Ph sician/ 0 an Known Medical resulting in death) Due to (or as a consequence of): Examiner Secure tially list c ... We as Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Year Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy funeral director, page 2 performe 2 🗀 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 🗌 Nursing Home 5 🗌 Residence 6 🗎 Other (Specify) Hospital 2 👿 No ၉ 1 🗌 Yes 1 M Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Man er of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 V Natural iniury 5 Pending work? 1 Pes 2 No 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours after deat To the Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗌 only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Dav. Year) and address of person who completed cause of death (Item 23a) (Type, Print) 30. Name Evant Baltimore, Mary 31. Date filed (Month. Day State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 18 per fb 9917 7-29-11 vt State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death I. Decedent's Name (First, Middle, Last) Day 2.7 Month JOHNSON Physician /Medical NARNER 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner **Baltimore City** The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 № M 2 🗆 F 212-36-2204 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location ral", or items 23a or 28a-f show Examiner must be notified at 10a State 10h. County 1 Yes 2 □ No Director rmore 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip-Code Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 2 No 1 Tes Specify: þ 3 Widowed 4 Divorced "natural", Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene.

is marked other than Store 17. Father's Name (First, Middle, Last) 18 Edith Na Earnestine Penmark Be Pages 1 and 2 should be 1 nent of Health and Mental I Johnson Relationship (Type. Frint) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, 19a. Informant's ltimore Maryland 21214 27 eboran Department of Healt Important: If item 2: any injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Toyn, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 Removal from State Crematon 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee dit ans 23a. Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HEART DISEASE ysician disease or condition resulting in death) Medical Due to (or as a consequence of) Pulmonary Disrace **Examiner** 003 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner use as the burial-transit The law requires that the death certificate be executed that initiated events and resulting in death) Last Due to (or as a consequence of) physician Box 68760, Physician/Medical attending IF FEMALE: 23d Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Year in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) ate has been signed by the appage 2 should be detached to Yes 2 No Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 4 Unknown 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy this certificate has performed' 2 🗌 No 1 Yes 25. Was case referred to medical the funeral director. 26. Place of Death Check only one Be examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 R/Outpatient 1 Inpatient 3 🗆 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 Pending investigation 1 Natural 2 Accident Injury 1 Tyes death. I or Attend after death Director: A 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital Funeral 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (check only one) and manner stated o the l 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number RES - 000 27,201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 JALAL

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, JUL 2 9 2011

Year)

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Anthony Fitzgeral		ohnson - For State	State o	of Maryla			nent of l cate of l		nd Mental I	пудіепе		201	1 24181
Dhysisian		Registrar 1. Decedent's Name (First, M	ddle.Last)			OCITIII				2. Date of	Reg. No. Death	201	3. Time of Death
Physiciar Medical Examin			GERAL	אסז ת	INSON					Month July 27	Day 2011	Year	0159 hrs
	ı	4a. Facility Name (if not institu	ution, give	street and nu					r Location of Dea			County of De	ath
		Johns Hopkins Bay						Baltimore	_				
Funeral		5. Social Security Number	6. Sex		7. Age (In	yrs. last b	irthday)	If Under 1 Year Months Day		Irs. 8. Date o	f Birth (MM/	For	Birthplace (State or eign
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ao y		Usual Residence of Deceden 10a. State 10b. Cour			10c.	City, Tow	n or Location	<u> </u>					10d. Inside City Limits
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the M	<u> </u>	3640 CHESTERF	IELD	AVE.				21	213		υ	.S.A.	
with ms 23	ᇙ	11. Marital Status	,	12. Was Dec		r in U.S.			ispanic Origin? (In, Mexican, Puer			14. Race - Am White, etc	erican Indian, Black,
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036 thin 7 than fedica	힏	12					SUPER	VISOR			WA	TER WA	STE DEPT.
5-0 Hygie		17. Father's Name (First, Mid	dle, Last)						18.Mother's Nar	ne (First, Mide	lle, Maiden	Surname)	
21215-0036 Mald be filed within 7 Mental Hygiene. Revent, the Medica	8	JEROME JOHNS 19a. Informant's Name/Relation				14	Oh Mailing /	Adres (Stra	EILEEN et and Number o			ty or Town St	ate Zin Code)
MD 2 d 2 shoul lth and M n 27 is m numatic e]≏	RHONDA ELDRID	, ,					-	RFIELD A				
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Baltimore, pemit. Pages I ar Department of Hee Important: If tiel	-	1 X Burial 2 Crema	_	Removal fr	1		atory or othe		lng.	-06-201	1 RA	LTIMOR	F WD
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Dep Dem		Daybay (//-				1120	6 W. NO	RTH AVE	BALT	MORE.	MD 21	217
Physician	1	23a Part I. Enter the disease failure. List only one da	or complic	cations that c	aused the d	death. Do	not enter the	mode of dying	, such as cardiad	or respirator	arrest, sho	ck, or heart	Approximate Interval Between Onset and
/Medical Examiner	1	Immediate Cause (Final dise	_	Sunshot W	_								Death
·	-	or condition resulting in death	יי Di b.	ue to (or as a	conseque	nce of):							
	احِ	Sequentially list conditions, if any, leading to immediate	D	ue to (or as a	conseque	nce of):		· ·	 _				
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executed an and al - transit	cal Examiner	events resulting in death) La	d.										
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68760, certificate be nding physicis	\$	IF FEMALE: 23b, Was decedent pregnant i	n the	23c. If yes,		fpregnand	_	Non a		4111	230	I. Date of delive Month	rery Day Year
certif	틸	past 12 months?		1 Live b	nant at time	of death	- =	I death 3 er (Specify)	Ectopic preg	mancy		Mortui	Day
Box e death c the atten	Physician/Med	1 Yes 2 No 9	Unknown	9 Unkno	own								
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iog Physician: After this certifuneral director	위	1 Yes 2 No 27. Manner of Death		28a. Date	of Injury		o. Time of Inj		ury at Work?	28d. Desc	ibe how inju	ry occurred	
onding ath.	틸		ending	17	Day, Year) 2011		28 hrs	1	Yes 2 No	Subject	shot		
Division tal or Attendic rs after death. al Director: A	<u>≅</u>		ould not be	28e Plac				factory, office	building, etc.				Rural Route Number, City
Dital o	Certification		etermined		Local S	Street				3600 bloc	k of Chest	erfield Aveni	ue, Baltimore, MD
		(CiteCh Unity							date and place, a n, death occurre				
complete the state of the state	Medical	one) 2 Medical I		and manner s		mon and/o	i livestigatio		se number	a at the time, t			Month, Day, Year)
	2	29b. Signature and title of cer) (.M.E.			27, 2011	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
ıí		30. Name and address of per	son who or	mnleted cour	se of death	(Item 22s	1)						
Ц								nore Street	, Baltimore, N	MD 21223			
Sta	te	31. Date filed (Month, Day, Ye		32 R	gistrar's Si	ignature	7	-1		Ť			
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DHMH 17 Rev 1/200)1			OCME		O	RIGINAL						

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** AM Constance elen 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Brightfield Road Baltimore 1. Litherville, MD If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) New Jersey 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year July 1, 1935 **Funeral** Days Hours 1 □ M 2 □ F 056-28-0767 76 Director Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland ealth and Mental Hygiene. n 27 Is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10d. Inside City Limits an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 1 ☐ Yes 2√☐ No MD **Baltimore** Lutherville Director 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 21093 515 Brightfield Road U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ Specify. White 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) traumatic event, the Homemaker Own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 0. Ankner ၉ William Kondolf Helen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any injury or other trau 160 Hobart Ave., Maureen T. Speirs-daughter Absecon, NJ 08201 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hilltop Serv Corp 7/28/11 Towson, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service I censee William G. Dau 1050 York Rd., Towson, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, aftending physician and Due to (or as a consequence of) Physician/Medical the IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 ☐ Pregnant at time of death 5 Other (specify) the a 9 Unknown 9 Unknown cate has been signed by a page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has autopsy 20 No 1∐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 5 Residence 6 □Other (Specify) After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? or Attending 1 Natural 2 Accident 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No after death 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours at To the Funeral D Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State
Registrar

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32. Registrar's Signatu

Withornelle

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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ate filed (Month, Day, Year)

JUL 29 2011

			Please	Type or Print in F	Black Indelib	le Ink. Ensure	All Copies A	re Legible	
			1 - For State Registrar	Type or Print in Amend ITEM#20 SMEND THEM#20 SMEND HEMP	d/Departmen b,perFH,G9 <i>Certificate</i>	t of Health and 19,976/2011 of Death	Mental Hygier ,WS	2011	24183
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36	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12, Was Decedent Ever in U.S. med Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	If Yes, speci	ent of Hispanic Origin? (S ify Cuban, Mexican, Puert 2 No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit	
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Ball	permit, Page Department Important: I any injury o		21. Sign when Fuperal Service Licenses	Gray	2222	Address of Facility	44. Ba	at Hoche	P.A.
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Division of Vital Records,	The law ate has page 2	Completed					24a. Was an autopsy performed?	prior to death?	topsy findings available completion of cause of
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	2			mpleted cause of death (Item 2	23a) (Type, Print) VIEW MEDICAL BACT (MVZ	LCENTER 30	MASON I	LURD DRI	VE SUITE #1100
	State Registra	~	31. Date filed (Month, Day, Year) JUL 2 9 2011	32. Registrar's Signatur	re elle				

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The County of th	Funeral		Future Care 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Yea 07/06/196	9. Birthplace (State or Foreign Country) New Jetsey
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? 24185 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death a HO min Age (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Months (Month, Day, BALTIMORE, MC Director Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No HARFOR 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2101 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Completed by 1 \square Never Married 2 \square Married Maryland 21215-0036 1 Yes 2 No permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exa If Yes, Give Specify. Specify 3 Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) WN HOME TOMEMAK Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ RAC Lda 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, I CENT IORDAN - DAUG Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other pla 4 Donation 5 Other (Specify) ANCASTER Sign tur of Funeral Service Licenses YORKRO, MONKTON, ND 21111. un FUNERAI + CREMATIONSERVICES or complications that caused to st only one cause on each line. 23a. Part 1. Enter the disease e death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only Immediate Cause (Final Onset and Death Ph_sician/ disease or condition resulting in death) Medical a consequence of): Examine Esquartielly list ecoditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year Unknown 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown . Were autopsy findings available prior to completion of cause of death? Hypo Kalemia 24a Was an within 24 hours after death.

To the Funeral Director, After this certificate has I autopsy performe . Was se referred to dical examiner? 2 No 1 Yes funeral director. Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🗷 No Other: ျ 1 Inpatient 2 Inpatient 3 Inpatient 2 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniury Natural 5 Pending work? 2 🗆 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Secrifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Narse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one 29b. Signatur title of certifie 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print)

dr

State Registrar 30. Name and address of person

2 9

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 201 24186 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 7-22-2011 Physician/ 252 A M Betty E. Mathai Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Hospital Center Westminster Carroll If Under 1 Year If Under 24 Hrs.
Months Davs Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🕱 F 83 Director Mary land 216-20-4543 1928 Ian Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD. Baltimore Hampstead 1 ☐ Yes 2 🛣 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 17905 Marshall Mill Rd. 21074 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black White etc. 1 Never Married 2 Married δ 1 Yes 2X No Specify: Specify: White 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. College (1-4 or 5+) +2 Elementary/Seconday (0-12) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Department of Health and Ment.
Important: If item 27 is marked any injury or other. Anthony Esworthy Margaret Mav Ramsburg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeffrey Mathai/ Son 5795 Clearspring Rd. Baltimore, MD. 21212 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 7/27/2011 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Co. Towson, MD. ^{22. Name and Address of Facility} Ruck Towson Funeral Home, 1050 York Rd. Towson, MD. 21. Signature of Funeral Sortice License 23a. Part 1. Enter the disease, or compare thons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between 5 EVERE SEPSIS Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): INFECTION **Examiner** URINARY TRACT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 month Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 1 Yes 2 No ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: မ 1 Inpatient 2 🗆 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide work?
1 Yes 2 No injury 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined

Records, the Hospital or Attending Physician: I hin 24 hours after death.
the Funeral Director: After this certifica Division of Vital completed filled in by

Box 68760

P.O.

Baltimore, Maryland 21215-0036

Registrar

Medical

29a. Certifier

(Check

FRANCIS

29b. Signature and title of certifier

KHOO MD 32. Registrar's Signature

, MD

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FRANKIS K-HOO MD 200 MEMORIAL AVENUE WESTMINSTER MD 2115)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D 30263

29d. Date signed (Month, Day, Year) 7-22-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dennis Mayer L. July 28ª 2019 7:44 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 2 Bantry Court Rosedale Baltimore Social Security Number 8. Date of Birth (Month, Day, Ye Aug. 23, If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday **Funeral** 9. Birthplace (State or Foreign Days Hours 1 **X** M 2 □ F 212-50-3792 **Director** 60 Baltimore, MD Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Rosedale 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2 Bantry Court 21237 United States be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian. Armed Forces?
1 X Yes 2 Black, White, etc. 1 Never Married 2X Married Completed by Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Vietnam Specify: White 3 Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry
United States (Specify only highest grade completed) Mental Hygiene. arked other than Elementary/Seconday (0-12) College (1-4 or 5+) Postal Service Mail Carrier Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked o ೨ permit. Page 1 and 2 should be Department of Health and Ment. Important: If item 27 is marked any injury or out. James Frederick Mayer, Sr. Helen Elizabeth Stroh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cherry Mayer- Wife 2 Bantry Court, Rosedale, Maryland 21237 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State August 1 1 X Burial 2 Cremation 3 Removal from State Poplar Gove united Phoenix, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2011 Methodist Ch. Cometery 21. Signature of Funeral Service License 22. Anne #Chapel & Cremation Services 8800 Harford Rd. Parkville, MD 21234 Rd. Parkville, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Myocardial Infarction isease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** COPD Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Exam certificate be executed and -trans that initiated events resulting in death) Last Due to (or as a consequence of): physician a the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months? Month Pregnant at time of death Day Year the Unknown g 🗌 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Diabetes Completed 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has t lirector, page 2 s autopsy perform 1 Yes 2X No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 🗌 Yes 2 X No Other: ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred injury XNatural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

13 / h

Karen Perkins MD 9101 Franklin Square Drive Ste. 205 Rosedale, MD 21237

31. Date filed (Month, Dáý, Year)

32 July 29 2011 July 5. Ju

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ron

Registrar

D0063731

7/28/2011

State Registrar 29b. Signature and title of certifier

E. Kalend Year)

9

Michelle

31. Date filed (Month

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number RO97104

RNP 1801 Wentworth Rd. Baltimore, Maryland

29d. Date signed (Month, Day, Year)

3

State Registrar

DHMH 17 Rev 1/2001

OCME 2006

Ling Li, MD

Date filed (Month, Day, Year)

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^D2011 July Physician/ Lula Rae 28. Marshall 6:35 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Glen Burnie Health & Rehab. Center Glen Burnie Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Sept. 28,1923 Mary Land 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 🗆 M 2 🕱 F Hours 214-24-5888 87 Director Usual Residence of Decedent 28a-f shov aţ 10a. State 10b County 10c. City. Town or Location 10d. Inside City Limits Director Examiner must be notified Maryland Anne Arundel Glen Burnie 1 Yes 2 No P 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 21061 United States 306 Shipley Ave. death 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc ь 1 ☐ Yes 2 🔯 No If Yes, Give <u>\$</u> 1 Never Married 2 Married Baltimore, Maryland 21215-0036 hours after 1 ☐ Yes 2 🛣 No Specify. "natural", 3 X Widowed 4 Divorced Specify: Completed White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) within 72 al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Factory Worker Manufacturing Be permit. Page 1 and 2 should be filed.
Department of Health and Mental Hy
Important: If item 27 is marked oth. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lula Rae Moon Walter Bayly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 306 Shipley Ave., Glen Burnie, Maryland 21061 Patricia M. Reese / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State July 30, 4 ☐ Donation 5 ☐ Other (Specify) Lakeview Mem. Gar. Sykesville, Maryland 21. Signat al Servi License 22. Name and Address of Facility Kirkley-Ruddick 421 Crain Hwy., Funeral Home, P.A. S.E., Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or s a consequence of **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Pregnant at time of death 2 X No 9 Unknown 9 Unknown þ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24a. Was an Were autopsy findings available prior to completion of cause of has autopsy death? certificate 2 🔯 No 1 Yes 2 No Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 🔀 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 🛮 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🛚 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year

Rani S. Karipineni,

29 2011

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202 W. Maple Rd., Linthicum, Maryland 21090

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32. Regis ar's Sig

M.D.,

Kan

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

July 28, 2011

Please Type or Print in Black Indelible Ink Fnsure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene for State Registrar Reg. N. 2 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2011 Month 19 Physician/ 4.548 M Mark McCoy Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BURNIE ANNE MEDICAL GLEN BALTIMORE WASHINGTON CENTE If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 🛛 M 2 🗆 F Nov 25, 1951 Michigan 59 **Director** 265-58**-**5705 Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County with the Maryland ms 23a or 28a-f sho Director 1 🗆 Yes 2 🄀 No Anne Arundel Pasadena MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? USA Funeral 1404 Rainbow Dr. 21122 permit. Page 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traummit." Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status - unk 12. Was Decedent Ever in U.S Armed Forces2unle Black, White, etc þ 1 Never Married 2 Married 1 Yes If Yes, Give 2X No white 1 ☐ Yes 2X No Specify. 3 ₺ Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12)
-unk 12 College (1-4 or 5+) Manufacturing Welder unk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Carlson James McCoy Joy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1404 Rainbow Drive Pasadena, Maryland Roger McCoy - brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 8/03/2011 Metro Crematory Inc. BAltimore, MD Cremations Society of MD 299 Frederick Ranald Wade rector 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or seart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final LHBUMONIA Physician/ disease or condition resulting in death) Medical FAILUPE Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death cate has been signed by the a page 2 should be detached it 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 Yes 2 No After this certificate 25. Was case referred to medical examiner? the funeral director, Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Mann of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: atural 5 Pending 1 🗌 Yes 2 🗌 No Investigation Accident 24 hours after death Funeral Director: 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one 29b. Signature pleted cause of death (Item 23a) (Type, Pright) Soi Hoccital drive Glen Burnie. . Name and address of person who comp State 9 Registrar

3x

State

Registrar

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

St

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Reg. No Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** me Minn N: 111am Oru, 1/e 1105 JU. /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Splina 2712 Gartield SILVEY MONTODINA 5. Social Security Number 6 Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days Vear! 1 X M 2 □ F Months Hours 91 December 8, Director 401-46-9448 1919 Tennessee Usual Residence of Decedent filed within 72 hours after death with the Maryland la or 28a-f show 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits Director 1 □Yes 2 No Maryland Montgomerv Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? .1 and 2 should be filed within 72 hours after death will Health and Mantal Hygiene.
tem 27 is marked other than "natural", or items 23a other traumatic event, It we Medical Examirer must to 2712 Garfield Avenue 20910 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XX Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 WWII 1 ☐ Yes 2 X No Specify: à 3 ☐ Widowed 4 🔀 Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Owner 5+ Optic Shop 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Herbert McMinn ပ Ada Roberta Searcy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wesley McMinn / Nephew 2311 Ovoca Road, other 1 Tullahoma, Tennessee 37388 permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🛱 Cremation 3 ☐ Removal from State July 29, 2011 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland Crematorium, Inc. 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. Chaptette Darnie 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part1. Enter the disease, or complications that caused the death. Shock, or licent failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** (OUngho! disease or condition resulting in death) VOUNN /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Hospital: 1 Yes 2 No Other: 4 \square Nursing Home Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of After 1 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 5 elf-insticted gun Unk 1 ☐ Yes 2 📉 No 2 Accident JU1 18 2011 **Director:** 6 Could not be determined 3 Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) nber or Rural Route Number home thin 24 hours at the Funeral D an 20910 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causes and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical YCheck only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

To the P within 2-

TO

State Registrar MMO DME

MY, DME

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 52

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BRECHER

31. Date filed (Month, Day, Year)

D 00428

11-05514
Robert Mason

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hydiene

CODER MASON	1- For S Registra		St	ate of Maryla		ertificate d		and	Mental F	,,	Reg. No.	201	1 2419
Physician Medical Examine	/ 1. Dece	dent's Nan	ne (First, Middl	e,Last)						2. Date of Dea	ath Day	Year	3. Time of Death 0505 hrs
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			aritan Hosp	oital			Baltimo	ore				N/A	
Funeral Director		Security I	Number 3279	6. Sex		. last birthday)	If Under Months		If Under 24H Hours Mi		•	1 Forei	
Director -			of Decedent	1X M 2 F		TL Y	rs.			5-2	26-194	49 C	ountry) MARYLANI
an A	10a. St		10b. County		10c. Cit	ty, Town or Loc	ation			_			10d. Inside City Limits
Maryland 28a-f show	MI	•	N/	A		BALTIM	ORE						1 X Yes 2 No
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s after iral", c	3 💷	Vidowed	-4.4	orced If Yes, Give Yea or Dates: cify only highest grad			Yes 2	n.				ecify: BLA	
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MD d 2 sho Ith and 127 is	RC	BERT	MASON (SON)		530	4 S. 8	7 PL	AZA OM	AHA, NEI	6812	27	
nore, MD 2121; siges I and 2 should be file int of Health and Mental I t: If item 27 is marked other traumatic evect;		thod of Dis Jurial 2		3 Removal fro		Place of Dispo crematory or o		of ceme	tery,	Date	20c. Loc	ation - City or	Town, State
Baltimore, permit. Pages I as Department of He Important: If ite injury or other tr	4 [[onation 5	Other Sp	ecify:	M'	r. ZION	CEMET:	ERY	7-	29-2011	BALT	FIMORE,	MARYLAND
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Division of Vital Records, P.O. Box 68760, Hospital or Atteoding Physician: The law requires that the death certificate be executed 24 hours after death. Figure 11 Property 12 After this certificate has been signed by the attending physician and rely filled in by the funeral director, page 2 should be detached for use as the burial - transit al Certification: To Be Completed by Physician/Madical Ex	23b. Was pas	decedent 12 months	pregnant in the ?	1 Live bi		2 F	etal death	3	Ectopic pregn	ancy			Day Year
Box death he atter d for u	1 🗆 Y	es 2 🗌 l	No 9 Unk	nown 9 Unkno		eatri 5 ☐ C	ther (Specify						
P.O. I see that the gned by the detache		ther signi	ficant condition	ons contributing to	death but not	resulting in the	underlying ca	use give	en in Part I.				the cause of death?
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tal Recipient The certificate ector, page		case refer	red to medical				26	Place of	Death (Check	1 Yes	2 No	1 🗸 Ye	s 2 No
f Vital Records, Physician: The law require r this certificate has been siral director, page 2 should b	exan	niner?	2 No	Hospital: 1 🗸 Ir	patient 2	ER/Outpatien				ng Home 5	Residence	6 Other	
After 1 After 1 funeral		ner of Deat Natural			of Injury Day,Year)	28b. Time of			at Work?	28d. Describe			
Division Lal or Atteodi rs after death. The Director of the file of the file Buttification	2 X	Accident		tigation 28e Place	-23-11	Unknow nome, farm, stre	11		2 X No	subject			ral Route Number, City
Division o Division o Spital or Atteoding hours after death. ceral Director: Aft filled in by the func Certification:	3 :	Suicide Homicide	6 Could determ	not be		known	ot, idotory, or	noo ban	anig, c.c.	or Town, S	tatal	Unknow	
Di To the Hospital within 24 hours a To the Fuocral I completely filled		tifier 1	CertifyIng Ph	ysician: To the best	of my knowle	dge, death occu	rred at the tin	ne, date	and place, and	due to the caus	e(s) and m	anner as state	ed.
To the He within 24 To the Fu completel:	one)		title of certifier	niner:On the basis o	t examination ated.	and/or investiga		icense n		at the time, date		and due to the signed (Mo	
			50	1/2-5/	006	388		C.M.				5, 2011	iii, Day, I Gai j
	30. Nam	and addr	ess of person	who completed cause	e of death (Iter	n 23a)							
10.			In MD JD	Assistant Med			V. Baltimo	re Stre	et, Baltimo	ore, MD 2122	23		
State Registra		filed (Mont	h, Day, Year)		jistrar's Signat	A Ma	Ver!						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND ITEM#8,20b, perfff, G918,8/9/2011, WS
State of Maryland / Department of Health and Mental Hygiens (1) 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 10:40 AM Larry A. Patterson 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 8. Date of Birth 22-1947 9. Birthplace (State or Foreign (Month, Day, Year) 7/27/1947 Manor Care- Towson Towson If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Days 1**X** M 2□ F 218-46-9791 63 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No N/A Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21205 USA 1400 E. Madison St. Pat. 1105 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) United States Elementary/Secondary (0-12) College (1-4or 5+) Flame Cutter Coast Guard 8th N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arnold Patterson Althea Pitts 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1400 E. Madison St. Apt. 1105 Balt.MD 21205 Gilda J. Patterson-Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 8/5/2011 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greenmount Cemt. 8/4/2011 Baltimore, MD 22. Name and Address of Facility March F/H 1101 E. 21. Signature of Funeral Service Licensee Ave. Baltimore, MD 21202 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Kena hronic Due to (or as a consequence of): iabetes seque tlany list or citicus, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Obstructive Pulmonary diseas Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an performed? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

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or items 23a

"natural"

I Hygiene.

and Mental Hygie is marked other

permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is

injury or other

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within 72 hours after death with

Baltimore, Maryland 21215-0036

notified

must be

the Medical Examiner

Director

Funeral

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Completed

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MD

Examiner Physician/Medical þ Completed Be

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

burial-trar physician the as for use þ signed by page 2 s certificate l this funeral Hospital or Attending Pl 24 hours after death. Funeral Director; After t After

Division or Vital Records, P.O. Box 68760, 冬

Certification: To the filled in by

within 2. To the I 6 Medical

24 hours a

29b. Signature and title of certifier

5 Pending investigation

6 ☐ Could not be

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

and manner stated.

110054424 7-27-11

Lutherwell, MD 21093

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30 Name and address of person who completed cause of death (Item 23a) (Type, Print) CYTUS ASACT, TO IZ Falls Croft Way

State Registrar

32. Registrar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hydiene O I I

		1 - State Amend Ite	em 23a per d	r.,g9	17 ,07/ Cer	28/2011 di tificate of D	i b eath	rontal m	Reg. N	2011	24190		
Physici Med		1. Decedent's Name (First, Middle LUCILLE MARIE E				-		2. Date of De		ay 20 Ĭ^ei r	3. Time of Death 11:00 P M		
Exami		4a. Facility Name (if not institution	n, give street and number)			4b. City, Town, or			40	c. County of Death			
Funera		86 TULIP DRIVE 5. Social Security Number	6. Sex 7. Ag	ge (In yrs. las	st birthday)	CONOWIN If Under 1 Year	If Under 24 Hrs.	8. Date of Bi	rth	th 9. Birthplace (State or Foreign			
Directo		218-14-6580 Usual Residence of Decedent		87	Yrs.	Months Days	Hours Min.	(Month, Da	ay, Year)	Coul			
land show d at	ρ	10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside City Limits		
Mary 28a-1 otifie	Director	MD CECI	L	CONO	WINGO						1 Yes 2X No		
ith the 3a or it be n	冒	10e. Street and Number				10f. Zip Code			10g. C	citizen of What Cou	ntry?		
ems armus	Funeral	86 TULIP DRIVE	12. Was Decedent		13. V	21918 Was Decedent of His	spanic Origin? (Spe	cify Yes or No		USA 14. Race - Ameri	can Indian.		
Maryland 21215-0036 2 should be filed within 72 hours after death with the Maryland Ith and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	b	1 ☐ Never Married 2 ☐ Mar 3 🛣 Widowed 4 ☐ Divorced	If Van Civa			f Yes, specify Cubar □ Yes 2 🛣 No	n, Mexican, Puerto I		Black, White, Specify: WHI	etc.			
15-C	Completed		nt's Education est grade completed)		(Give I	lent's Usual Occupa kind of work done du	tion uring most of worki	ng	16b. I	Kind of Business Ir	idustry		
vithin vithin vithen.	Con	Elementary/Seconday (0-12)	2 College (1-4 or	5+)		O NOT use retired) ING GUARD			BAI	LTIMORE C	O. POLICE		
and and and and and and and and and and	Be	17. Father's Name (First, Middle,	Last)				18. Mother's Name	e (First, Middle	, Maiden	Surname)			
Marylaı should be n and Menta 7 is marked raumatic e	12	JOSEPH WOLOSIK					HELEN MA	RIE TO	MASZ	ZEWSKI			
Mar 12 shou lith and 27 is n		19a. Informant's Name/Relations MAURICE PIPPIN.		11		ng Address (Street ar LIP DRIVE					Code)		
ore, Marylar T and 2 should be Health and Ment fitem 27 is marker r other traumatic		20a. Method of Disposition		20b. Pla	ace of Dispo	sition (Name of		Date	T	Location - City or T	own, State		
Baltimore, bermit. Page 1 and Department of Heal Important: If item any injury or other once.		1 ☐ Burial 2 🙀 Cremation 4 ☐ Dona¶on 5 ☐ Other (\$		-		CREMATORY	` i	6/11 -	GI	EN BURNI	E. MD		
Baltimo permit. Page Department (Important: If any injury or once,		21. Signature of Funeral Service I	_icen_Ce								E OF BELAIR		
		23a Part Enter the disease of	complications that cause	d the death		510 W. MA				R, MD 210	14 Approximate		
∼Ph√sician/		shock, or heart failure. List only one cause on each line.											
Medica	1	disease or condition resulting in death)	a. Due to (or as	a conseque	ence of):	2 4411	UFE		_	-	Onset and Death		
Examiner		Sequentially list conditions,	D	LVPA	= TO	THRIVE	έ				2 WEEKS		
ped sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as Dem	a conseque	,						l year		
8 760 ificate be executed ig physician and as the burial-transit	Exa	that initiated events resulting in death) Last	c. Due to (or as	a conseque	ence of):								
60 te be e hysicia he bur	Medical		d										
68760 ertificate b ding physi se as the b		IF FEMALE:	23c. If yes, outcome	of program	01/			-					
BOX 6 death cert he attendir	Physician/	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 Live Birth	2 Fetal	death 3	Ectopic pregnancy Other (specify)	′		Ì	23d. Date of delive Month	very Day Year		
the de by the ached	hysi	9 Unknown	9 🗆 Unknown										
s that the	þ	Part II. Other significant condition	ons contributing to death I	but not resul	Iting in the u	nderlying cause give	en in Part I.				the cause of death?		
ords require been s should	eted										bably 4 Unknown		
DIVISION OT VITAI RECORDS, P.O. BOX 63 To the Hospital or Attending Physician: The law requires that the death certi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendin completed filled in by the funeral director, page 2 should be detached for use.	Completed							24a. Was auto perf 1 Yes		prior to co	opsy findings available ompletion of cause of		
'Ital sician: certifi rector,	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:			Other	ce of Death (Check						
OT V g Phys er this ieral d	e: To	27. Manner of Death	28a. Date of inju	ury 2	8b. Time of	28c. Injury	4 U Nursing Hor	me 5 Resi		6 Other (Specifing occurred)	0		
eath.	ficat	1 Natural 5 ☐ Pendir 2 Accident Investi 3 ☐ Suicide 6 ☐ Could	gation	iy, Year)	injury	work? M 1 □ Y	∕es 2 □ No						
DIVISION OT tal or Attending PI rs after death. al Director: After the	Certificate:	4 Homicide determ			ne, farm, stre	eet, factory, office	2	28f. Location (City or To		nd Number or Rura e)	l Route Number,		
DIVISION Of WITAI To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	29a. Certifier 1 Certifying (Check 2 Medical E	Physician: To the best of examiner; On the basis of e	f my knowled	dge, death c	occured at the time, o	date and place, and	d due to the ca	ause(s) a	and manner as state e, and due to the ca	ed. ause(s) and manner stated.		
To the vithin 2 or the omple	ž		Nurse Practioner: To the				time, date and place		ne cause		tated.		
(191m	lh			MD	0 Obb 32-	۱		7/20/201	1		
2 de		30. Name and address of person	who completed cause of c	death (Item 2	23a) (Type, P	37	FRSING	5 5 1	1	M10 71	91,		
Sta		31. Date filed (Manth, Day, Year)	32. Registr	ar's Signatu	re	- 1701-1	140	1 100	1 2		- ()		
Registi	ar	~ U 201	Lewe	13. 1	Barra								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ J_{uly}^{Month} ^{Day} 2011 Margaret Roselee Qualls 23 12:53 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 7424 Hawkins Drive Hanover Anne Arundel Date of D. Month, Day, Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days Hours Min 1 M 2 X F Months 256-16-8686 91 1919 Georgia Director Nov. Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Anne Arundel Hanover 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral 7424 Hawkins Drive 21076 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify: Specify. 3 Widowed 4 Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) th and Mental Hygiene. 27 is marked other than traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. Frank Blount Maggie Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lois Jones / Daughter 7424 Hawkins Dr., Hanover, Maryland 21076 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of ^{Date} 26 2011 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) Ju1y 4 Onation 5 Other (Specify) Crownsville MD Vet. Cem. Crownsville, Maryland un ral Service 21. Signat Rirkley-Ruddick Funeral Home, P.A. 421 Crain Hwy., S.E., Glen Burnie, MD 21061 OX 23a. Part 1. There the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine Due to lor as a consequence of if any leading to immedicause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the use as 1 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy the atter in the past 12 months?
1 ☐ Yes 2 ☒ No Month Dav Year Pregnant at time of death signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s performed certificate 2 No Yes 2 X N 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 \square Nursing Home 5 \boxtimes Residence 6 \square Other (Specify) 1 🗌 Yes 2 🔀 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at Certificate: 1 🔀 Natural 5 Pending work?
1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title q 29c. License numbe 29d. Date signed (Month, Day, Year, July 25, 2011

Registrar

7845 Oakwood Rd., Suite 200, Glen Burnie, Maryland 21061

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatur

Peter Ramirez, M.D.,

31. Date filed (Month, Day, Year)

JUL 29 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month MARIO ROMAGNOLI 2011 JULY 9:08 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death UPPER CHESAPEAKE MEDICAL CENTER HARFORD AIR If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Days Hours 212-20-2770 8/47/1924ar) MARYLAND Director 86 Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown any injury or other traumatic event, the Medical Examiner must be notified at once. Director 10a. State 10c. City, Town or Location 10d. Inside City Limits MD HARFORD BEL AIR 1 🗌 Yes 2 ី No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 300 RING FACTORY ROAD 21014 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify Completed 3 X Widowed 4 Divorced WWII WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 6 YEARS TEACHER BALTIMORE CO. SCHOOL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) PASQUALE ROMAGNOLI CRISTINA PASSARO 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 805 FOX BOW DRIVE BEL AIR, MD MARK J. ROMAGNOLI/SON 20a. Method of Disposition 20b. Place of Disposition (Name of 1X Burial 2 Cremation 3 Removal from State DULANEY VALLEY MEM. 8/1/2011 4 ☐ Donation 5 ☐ Other (Spacify) COCKEYSVILLE, CARDENS 21. Signature of Funeral Sérvice Licensee MO1139 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 Part 1. Enter the disease, or conf, lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only ne cause on each line. heart failure Immediate Cause (Final Physician/ disease or condition resulting in death) y caus Medical Examiner diabetes mellitus, type II Sequentially list conditions, if any, leading to minediate cause. Enter Underlying Cause (Disease or iinjury tu (ur as a consequence of). Uyp cricusion Examine Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical obesity P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of autopsy perform death? 1 ☐ Yes 2 ☐ No Yes Division of Vital 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 1 XYes 2 ☐ No Other: 1 Inpatient 2 KER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work? 1 🔲 Yes 2 🗌 No Investigation 6 Could not be 2 Accident
3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Xcertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated D0034193 July 28, 2011 completed cause of death (Item 23a) (Type, Print) Luthewille, MD 21093 Rd.

Registrar

State

10755 Falls

31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Michael Scott Radcliffe Physician/ 22°, 201°1° 6:30 A. M July Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death
Timonium Examiner Baltimore County unit 109 12246 Roundwood Road 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours 214-72-7409 Dec. 13, 1956 Philadelphia, PA. **Director** 54 Usual Residence of Decedent fshow at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Department of Health and Mental Hygiene. Important; if items 23a or 28a-fs Important; if item 27 is marked other than "natural", or items 23a or 28a-fs important; if item 27 is marked other than medical Examiner must be notified one. Timonium 1 Yes 2 No Baltimore County Maryland 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21093 12246 Roundwood Road unit 109 Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14, Race - American Indian, Armed Forces?
1 Yes 2 No Black, White, etc 1 Never Married 2 Married þ Yes Page 1 and 2 should be filed within 72 hours after altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White If Yes, Give Specify: 3 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) Criminal Defense Lawyer Be 17. Father's Name (First, Middle, Last) 8. Mother's Name (First, Middle, Maiden Surname) **Theodora C. Van Wyk** M. Stanley Radcliffe 19a. Informant's Name/Relationship (Type, Print) (Brother) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7809 Limestone Court Ellicott City, MD. 21043 Mr. Stuart Van Wyk Radcliffe 20a. Method of Disposition
1 □ Burial 2 ☐ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of Sunday, 20c. (Harford County) Evans fureral Chief and Cremation Services, Inc. July 24,201 Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Jeffrey

L. Gair, Sr. CSP ame and draw of Facility was Funeral and Cremation Ctr. P. A

Lic. #1000 Timonium, Maryland 210932215 Part 1 Effect the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ a my o disease or condition Medical resulting in death) Due to (o as a conse ence of) **Examiner** Sequentially list conditions, il any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of, attending physician and for use as the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) Dav Pregnant at time of death been signed by the should be detached 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Hospital or Attending Physician: The law after death.

Director: After this certificate has page 2 s autopsy 1 Yes Division of Vital 25. Was case referred to edical completed filled in by the funeral director, 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Tes 2 No-ည 4 Nursing Home 5 Residence 6 Other (Specify 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate; 28d. Describe how injury occurred 1 Natural 5 Pending М Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after to the Funeral Direc determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in manufacture death. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 101 28030 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMONE, UN COUNBL JOHNS HOPKINS 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 24200 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Constance Louise Rhoades 7:45 PM JULY 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner TOWSON BALTIMORE SAINT JOSEPH MEDICAL CENTER Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **87** Yrs. If Under 1 **Funeral** Months Davs Nov. 21, 1923 187-14-0786 Altoona, PA. **Director** Usual Residence of Decedent show 10d. Inside City Limits if of Health and Mental Hygiene.
If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10a. State Director 1 🗆 Yes 2 📥 No **Baltimore County** Nottingham Maryland 10e. Street and Number 10f. Zip Code itizen of What Country? United States 21236 Funeral 4206 Garland Ave. 12. Was Decedent Ever in U.S. Armed Forces 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 No Specify: White Specify 3 ₩ Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired)_ (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Retail Sales Sears Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Emma Elizabeth Carsel ဂ W. Max Keirn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4206 Garland Ave. Nottingham, Maryland 21236 Department of Health an Important: If item 27 is any injury or other trau Mr. Mark I. Rhoades (Son) 4206 Garland Ave. 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Parkwood Cemetery 20c. Location - City or Town, State Tuesday, July 26,2011 Parkville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Gervice Licensee Jeffrey I. Gair, Sr. O. 32. Name and Address of Facility. Penceful Alternatives Funeral and Cremation Center, P.A.

Lic. #M00677 225 York Road Timonium, Maryland 21093-2215 23a. Rart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Diset and Death ASPIRATION PNEUMONIA Immediate Cause (Final disease or condition Ph_sician/ Medical resulting in death) Due to (or as a consequence of) **Examiner** PERFORATED VISCUS AFTER PERCUTANEOUS ENDOSCOPIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami attending physician and for use as the burial-transit GASTROSTOMY ACCOMMODATION INSERTION Cause (Disease or iinjury that initiated events EXAMINER Physician/Medical DAYS EHYDRATION ON ADMISSION P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death IF FEMALE CERTIFIC 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No signed by the atte Month Day Year 1 Yes 2 2 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ALZHEIMERS Division of Vital Records, 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 2 ☐ No 1X Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending SubJect PerForated 2 Accident 1 Yes 2 X No July 21,2011 12:00 PM Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 7601 OSLER DRIVE 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined T JOSEPH TOWSON, MARYLAND 21204 MEDICAL CENTER Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check з 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. D25886 01 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OSLER DRIVE TOWSON, MARYLAND 21204 7601

State

Registrar

31. Date filed (Month

Day, Year)

29

Division or Vital Records, P.O. Box 68760,

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		For State Registrar			State of	of Ma	arylan		artmen ertificat				nental F	Reg. N	0.0		242	201
Physicia /Medic		Decedent's Name Nancy		,									2. Date of Month July		9	2011	3. Time of 7:55	
Examin		4a. Facility Name (I		n, give st		umber)			1	Town, or		of Death		4		ty of Deat Balti		
Funeral Director		5. Social Security N	lumber	6. Sex	M 2 X F	7. Ag	e (In yrs. i	last birthday Yrs.	1177			r 24 Hrs. Min.	8. Date of (Month) July	Birth Day, Yea	913	9. Birt New	hplace (State o untry) Hampshi	or Foreign .re
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 ☐ Never Marr 3 ☒ Widowed		ried	 Was Dec Armed F 1 ☐ Yes If Yes, G Year or I 	forces? 2 📉 f live		5. 13	. Was Dece If Yes, spe 1 ☐ Yes		Specify		Rican, etc.))	Black, White, etc. Specify: white			
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permit. F Departm Importar any Injur	4 MDonation 5 Other (Specific) 21. Signature of Funeral Service Licensee Ronald S Wades Birector 655 W. Baltimore St; Baltimore, MD										21201							
Physician /Medical Examiner		Immediate Cause disease or condition resulting in death)	art failure. Lis (Final on	r complice t only one	Due to	each li	I the death ne. a conseq	StA	nter the mod			as cardiac		ry arrest,			Approxima Interval Be Onset and	tween
leath certificate be executed attending physician and for use as the burial-transit	dical Examiner																	
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicia completely filled in by the funeral director, page 2 should be detached for use as the bur	Physician/Medica	IF FEMALE: 23b. Was deceden in the past 13 1 ☐ Yes 3 9 ☐ Unknown	months?	23		birth gnant a	pf pregna 2 □ Feta t time of d	I death 3	□Ectopic p □ Other (s)		/					Date of de Month	livery Day	Year
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nding Physician: The lav th.:: After this certificate has e funeral director, page 2 s	tion: To	27. Manner of Dear	th 5 🔲 Pendii	ng igation	28a. Date	e of Inju		28b. Time Injury	of :	28c. Injur Wor			28d. Desc				эспу)	
To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could deterr		28e. Plac buil	ce of inj ding, et	ury - At ho c. <i>(Specif</i>	ome, farm, s	street, factor	y, office				on (Street r Town, S		mber or R	Bural Route Nu	mber,
he Hospit n 24 hours he Funera pletely fille	Medical (29a. Certifier (Check only one)	1 Certifyi 2 Medica	ing Phys I Examin	ician: To the er: On the and ma	basis o	f examina	owledge, deation and/or	ath occurred investigation	at the ting	me, date opinion, d	and place leath occu	e, and due to	the causime, date	e(s) and and plac	manner a ce, and du	s stated. e to the cause	(s)
To the within 7	Ň	29b. Signature and	tithe of certifie	er			ME	>	29	c. Licens	e number	465		29d.	Date sig	ned (Mon	th, Day, Year)	
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Sta Registr		31. Date filed (Mor	oth, Day, Year UL 29	2011	Sen	Hogistr	ar's Signa	fa	Mal									

7005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 26, Day 2011 Year 7:45 am Marie Rohrbach Teresa Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Genesis Multi-Medical Baltimore Towson Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days Hours Director Marvland 213-20-8708 86 Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits Director the Medical Examiner must be notified Parkville MD Baltimore 1 Yes 2 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 7815 Oakleigh Road 21234 Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. ant: If item 27 Is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo Black, White, etc. þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. White 3 X Widowed 4 Divorced Specify: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)
411 Operator Elementary/Seconday (0-12) College (1-4 or 5+) C & P Telephone 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Harrison, Sr. Helena Wolf Marion Mary Robert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7815 Oakleigh Rd., Parkville, MD Roberta T. Lewis-daughter Department of Health
Important: If item 2
any injury or other I
once. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Baltimore National 7/29/11 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee William G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home, 1050 York Rd., Towson, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ementia disease or condition resulting in death)) vears Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown To the Hospital or Attending Physician: The law requires that the within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown CerebrovascularDiseuse 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? performed? 1 ☐ Yes 2 ☐ No **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☐ No Other: မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 \square Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

State Registrar only one)

29b. Signature and title of certifier

JUL 29

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Elkridge, MD 21075

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Effic Month Physician/ Day Sco # 2:20 P M JULY Zeil Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Seasons Hospice Randallstown Baltimore If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 F 213-34-5021 111°15-1929" Director 81 Yrs Usual Residence of Decedent show ral", or items 23a or 28a-f sho Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Pikesville 1 ☐ Yes 2🏋 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 7907 Grisford Place, Apt. G 21208 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 and 2 should be filed within 72 hours after the feath and Mental Hygiene.
Item 27 is marked other than "natural", or 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. 3 X Widowed 4 Divorced Specify: African-American traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Domestic Engineer Danestic 10th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Charles Williams Hazel Meades 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17251 Russett Farm Drive Shrewsbury, PA 17361 Rochelle Y. Sanders/Daughter injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place 7-28-2011 Baltimore, MD 22. Name and Address of Facility Wylie Funeral Home PA. of Baltimore Co. 9200 Liberty Road, Randallstown, MD 21133 and 1. Enter the discusse, or conshock, or heart failure. List rplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest one cause on each line. Approximate Discase Onset and Death Immediate Cause (Final End-Stage Liver Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of) physician and s the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death 2 No or meruneral Director, After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death.

Funeral Director: After this certificate has 1 Yes 2 No Yes 2 V No Be 25. Was case referred to medical 26. Place of Death (Check only one) 6 Tother Specific 1 ☐ Yes 2 ☑ No Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred the Hospital or Attending 1 Natural injury work? 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 2 🗌 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Cartifying Nurse Practioner: To the best of my knowledge, death 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 115 Ray apalose M. D 7/27/11 00057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MD 21209 5. 203 5. Rajapakse, M.D 2835 Smith 31. Date filed (Month, Day

Registrar

JUL 29 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month July 2011 **1;**45 \mathbf{p}^{M} Iona Smith Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 3316 W. Franklin Street Baltimore n/a 7. Age (In yrs. last birthday)
90 Yrs. If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 💢 F Months Hours Min. (Month, Day, 11**–7–1**920 Country) 212-24-9459 **Director** Usual Residence of Decedent ortant; If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director n/a Baltimore 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? by Funeral 3316 W. Franklin Street USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 ☐XNo If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examir Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: African-American 3 x Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 9th Housewife Damestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Avery Ray Ida Young 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beatrice S. Caldwell/ Daughter 7943 Don Drive, Pasadena, MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland National Cemetery 7-30-2011 Laurel. MD 22. Name and Address of Facility Wlie Funeral Home P.A. of Baltimore Co. 9200 Liberty Road, Randallstown, MD 21133 art 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure, dist only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ SEIZURE LUEEL Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated sease or iinjury Examiner Due to (or as a consequence or). physician and the burial-transi Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ▼ No 5 Other (specify) Month Year Dav been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? PREUMONIA 1 ☐ Yes 2 📈 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an After this certificate has funeral director, page 2: performe 1 🗌 Yes 2 🗌 No 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 1 Natural 28b. Time of 28d. Describe how injury occurred injury 5 Pending 124 hours after death e Funeral Director: A lleted filled in by the f Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completed f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 2 29c. License number

Registrar DHMH 17 Rev 7/2009

45em

Smith

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Morows

Date filed (Month, Day, Year) 29 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			for State Registrar	State of	Marylan		ertificate of		ia Mentai Hy	Reg. No.		24205
#	Physici	an	1. Decedent's Name (First, Mid Isaac	Robert	Sina	4			2. Date of D	Day		3. Time of Death 2:06 P M
Vi.	/Medic	_	4a. Facility Name (If not instituti				4b. City, Town, o	Location of I	July Death	21,	County of Dea	
	Examin	er	Hebrew Home of	-	,	on		kville			Montgo	merv
7	Funeral		Social Security Number	6. Sex 7	. Age (In yrs. I		/) If Under 1 Year	If Under 24	Hrs. 8. Date of Bi	rth	9. Bir	thplace (State or Foreign
	Director		197-36-8878 Usual Residence of Decedent	1 ∑ M 2□ F	86	Yrs.	Months Days	Hours	Min. (Month, D	0,19	24 Li	thuania
	yland now at		10a. State 10b. Coun	ty	10c. City	, Town or	_ocation					10d. Inside City Limits
	e Man 3a-f sh tiffied	Funeral Director	MD Mon	ntgomery		R	ockville					1XXYes 2 □ No
	vith th	Dire	10e. Street and Number	n.t			10f. Zip Code	250		Ü	izen of What Co	·
	s 23s	era	6105 Montrose	12. Was Deced	ont Ever in II	e 140		352	2 (Specify Ves or N		ited St	
980	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status 1 □ Never Married 2√√Ma 3 □ Widowed 4 □ Divorce	arried Armed Ford 1 ☐ Yes 2 If Yes, Give	es? 2 ⊠ No	3.	. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ሺ No	Specify:	Puerto Rican, etc.)		Black, Whit	
5-0	72 ho 'natur dical	eted		ent's Education hest grade completed)		(Gi	edent's Usual Occup re kind of work done	durina most o	f working	16b. K	ind of Business	/Industry
Baltimore, Maryland 21215-0036	within ene. than "	Completed	Elementary/Secondary (0-12)	College (1-4	4or 5+)		fessor -		na1		Educat	ion
d 2	filled Hygi other ent, t		17. Father's Name (First, Middle				105501		Name (First, Middle	e, Maiden		
lan	should be f and Mental I s marked of umatic eve	To Be	Boris	Ski	kne			Ella		Zo	tnick	
ary	shou and N s mai		19a. Informant's Name/Relation	nship (Type. Print)		19b. Ma	iling Address (Street	and Number	or Rural Route Num	ber, City o	or Town, State,	Zip Code)
Σ :	1 and 2 Health a em 27 is		Joshua B. Sin	ıai / Son			7 Pasture			-		0854
ore	ges 1 It of H If iter or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	n 3 □Removal from S	tate		position (Name of rematory or other place	1	Date		ocation - City or	
Ē	it. Pa intmen intant: injury		4 Donation 5 ☐ Other 21. Signature of Funeral Service				ed Sers. 1		the transfer of the second		thesda,	MD
Ba	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once.	6 1	> Stephilox	Elman	M0038	0	22. Name and Addre Rapp Fune: 933 Gist	Ave.,	Silver_Spi	ing,		20910
В			23a. Part1. Enter the disease, shock, or heart failure. Li	or complications that cal ist only one cause on ea	used the death ch line.	. Do not e	nter the mode of dyir	ig, such as ca	ardiac or respiratory	arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	W. Comment	Linsons		diseas	K.				
	Examiner			Due to (o	r as a consequ	ience of):						
		ner	Sequentially list conditions, if any, leading to immediate cause. E terminate cause (Disease or injury that initiated events	b. Due to (o	r as a consequ	uence of):						
	ecuted nd transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c								
60,	ificate be executed g physician and as the burial-transit	E	resulting in death) Last	Due to (o	r as a consequ	ience of):						
68760,	icate l physic	edical		d								
Box (death certific e attending p id for use as	in/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	ome pf pregna th 2 ☐ Feta		B⊟Ectopic pregnanc	,			23d. Date of de	
O. B	0 0	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		nt at time of d		Other (specify)				Month	Day Year
Д.	The law requires that the di ate has been signed by the bage 2 should be detached	by Ph	Part II. Other significant cond	itions contributing to dea	th but not resu	ılting in the	underlying cause giv	en in Part I.	23e. Did	tobacco	use contribute t	o the cause of death?
rds	equires en sig ould be	ed b							1□	Yes 2	M No 3□F	robably 4 Unknown
or Vital Records,	law re as be	Completed							24a. Wa	s an opsy	24b. Were a	utopsy findings available completion of cause of
三 三		Con								formed? 2. ☑ No	death?	s 2□No
Vit	Physician: this certificatal director, a	Be	25. Was case referred to medic examiner?	Hospital:			Oth		f Death (Check only			
or	Phys rathis rat dir	- T	1 Yes 2 No 27. Manner of Death	1 □ In 28a. Date of	patient 2 Injury	ER/Outpat 28b. Time		4 La ivurs	ing Home 5 ☐ Res			ecify)
on	Attending r death. ector: After by the funer	tion	1 XNatural 5 ☐ Pend		, Day Year)	Injur	/ Woi	k? Yes 2∐No			,, 55551164	
Division	r Atter er deal rector by the	Certification:	3 ☐ Suicide 6 ☐ Coul	rminad Zoe. Place C	ا of injury - At ho g, etc. <i>(Sp</i> ec <i>if</i>)		street, factory, office		28f. Location City or To	(Street ar	nd Number or F	Rural Route Number,
Ā	ital or irs after ral Dire			(V								
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	edical		ying Physician: To the b cal Examiner: On the bas and manne	sis of examina							
	To th within To th	Me	29b. Signature and title of certi	fier			29c. Licens	e number		29d. Da	ate signed (Mor	nth, Day, Year)
			min 7	nzli			Doo	64871		7-	21-11	
_	>		30. Name and address of person				e, Print)		1			
			Mina Fazl		21 Mo	ntros	e Rd ?	Rock	rille MD	208	25	
	Sta Registi		31 Date filed (Month, Day, Yea	Deneva A	gistrar's Signa	Land						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 24206 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Phyllis Marie Sellers Month 07-22-201 2:50 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore. Manor Care Rosedale 9. Birthplace (State or Foreign Country) Pennsulvania 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last hirthday) 8 Date of Rirth Funeral (Month, Day, Y Days Min. 1 □ M 2 🔀 F 84 179-20-5592 **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatht and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maruland Harkord Aberdeen 1 ☐ Yes 2 🛛 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States of America 802 Maxa Road 21001 11, Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Completed by 1 ☐ Yes 2 📈 No If Yes, Give 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Family Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name *(First, Middle, Maiden Surname)* Marie Harbold Carl Blouse 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Rural Route Number, City of Town, State, Zip Code) 802 Maxa Road, Aberdeen, Maryland 21001 Dianna M. Tilton (daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State RA Ferris & Co Inc. 07/25/2011 WestChester, Pennsylvania 4 Donation 5 Other (Specify) 22. Name and Address of Facility Zellman Funeral Home, P.A. 21078 123 S. Washington St., Havre de Grace, Maryland 23a. Part 1. Enter th, de ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart filture. List only one cause on each line. Immediate Cause (Final ASWD Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter oncertying Cause (Disease or iinjury Examiner Due to (or as a consequence of) requires that the death certificate be executed attending physician and for use as the burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available cate has b autopsy prior to completion of cause of death? certificate 2 No 1 Yes the Hospital or Attending Physician: 1 thin 24 hours after death. the Funeral Director: After this certifics mpleted filled in by the funeral director, p 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗆 Yes ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 14 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No. 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

73 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 7/2009

State

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day 2-6 Physician/ Month SINAY SIM 230 AM 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard Howard County General Hospital Columbia 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Social Security Number 1 🗆 M 2 🕱 F Jan Tay, 1948 Cambodia **Director** 63 58**6**-36**-**7921 Usual Residence of Decedent ms 23a or 28a-f show must be notified at id be filed within 72 hours after death with the Maryland Mental Hygiene. arked other than "natural", or items 23a or 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No Maryland Ellicott City Howard 10e. Street and Number 10g. Citizen of What Country? Funeral United States 21043 3000 N. Ridge Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc Yes 2 No Yes, Give þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Completed Specify: 3 Widowed 4 Divorced Asian Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Service Worker Food Service 6 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fill Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev ပ (unk) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other to once. 12051 Windsor Moss Ellicott City, MD 21042 Anne R. Dutra / Friend 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 8/1/2011 Woodbine, Maryland 21. Signature of Funeral Service Licens Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the please, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ HEPATIC ENCEPHALOBATHY disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** CIRRHUSIS OF Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). B INFECTION HEPATITIS the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Dav Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DIAPETES MELLITUS Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed HYPOTHYROIDISM 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? HYPERTENSION 2 🗌 No Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 1 No Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) apleted filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident
Suicide 1 Yes 2 🗌 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) D0043662 VUL 26

Registrar

DHMH 17 Rev 7/2009

State

5755 Cedar Lane Columbia, MD 21044

30. Name and address of parson who completed cause of death (Item 23a) (Type, Print)

HCGIT

32. Registrar's Signature

William Bonce

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 1030 2011 RRENDA JUL 5 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore 1635 Joplin St. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Dec 27, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Maryland Director 69 212-40-6278 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyghen. Int. If Item 27 Is marked other than "hatural", or items 23a or 28a-f show rint. If them 27 Is marked other than "hatural", or items 28a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Baltimore Director 10g. Citizen of What Country? 10f. Zip Code 21224 10e. Street and Number 1635 Joplin St. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married white 1∐Yes 2∏No Specify: Completed by 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) food industry fast food counter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rosa Sue Pecht George E. Hopple ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any injury or other trau once. 56 Blister St; Middle River, Maryland 21220 Denise Senters - daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 XDonation 5 ☐ Other (Specify) 22. Name and Address of Facility State Anatomy Board 21. Signature A runeral Service Licensee Director 655 W. Baltimore St; Baltimore, MD 21201 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Final **Physician** HUNTINGTON'S DISEASE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the death certificate be executed sician and burial-tran Due to (or as a consequence of) physician Physician/Medical the as attending | nse 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 PULMONARY 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performe this certificate 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Tesidence 6 Other (Specify) 2 No P 1 ☐ Yes 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

State

Registrar

Hayashi 5505 Hopkins Bayview Circle Balt., MD 21224 Jennifer 31. Date filed (Month, Day, Year) -

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division or Vital Records,

29c. License number

29d. Date signed (Month, Day, Year)

144

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 24209 Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Mont Physician/ 0255AM Delmas M. Schroyer Jr. 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Washington Meritus Medical Center Hagerstown 8. Date of Birth NoV 22, 1947 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 1 X M 2 □ F Hours Maryland Yrs Director 63 219**-**44**-**3814 Usual Residence of Decedent 28a-f shov 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director MD Hagerstown 1 🗆 Yes 2 🔀 No Washington 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 13220 Greencastle Pike 21740 USA within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 No Black, White, etc 5 1 Never Married 2 X Married ģ Yes Yes, Give 3altimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: "natural", 3 Widowed 4 Divorced Specify. Completed Year or Dates the Medical unk 16a. Decedent's Usual Occupation UNK (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) ad wh.

al Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) airline h and Mental Hygier 7 is marked other to traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Gloria Earnsteen Swanson Delmas Monroe Schroyer Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health 13220 Greencastle Pike; Hagerstown, MD 21740 Kimberly A. Schroyer - wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ŏ Important: If it any injury or o Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) 21. Sign 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Safer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) transitrequires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of): physician the burial Medical Division of Vital Records, P.O. Box 68760 the attending phohesist the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Day Pregnant at time of death Unknown 9 Unknown signed by tared by tared be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Yunknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas page 2 autopsy certificate ! PERIPHERIAL 1 Yes 2 No Yes 2 😾 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 🗷 No Hospital Other: ပ 1 Tes 1 Nation 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred iniury work?
1 Yes 2 No 1 Natural 5 Pending Accident Investigation the Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 2 hours

State Registrar 11116

Medical

HAGERS TOWN MY

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Harold Arthur Siler July Physician/ 20^{Year} 7:07 A M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Harford Upper Chesapeake Medical Center Bel Air 9. Birthplace (State or Foreign Country)
Maryland If Under 8. Date of Birth
May 10, 1936 Social Security Number 7. Age (In vrs. last birthday) 1 Year If Under 24 Hrs. **Funeral** Months Days Hours Min 1 X M 2 - F 216-32-3279 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "not more..." 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director 1 Yes 2 XNo Bel Air Maryland Harford 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral USA 1703 Kendall Gate Way 21015 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, rmed Forces?

XYes 2 \(\sum \) No Black, White, etc. 1 Never Married 2 Married Completed by If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Procurement Officer U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Cora (nmn) Hunter Harry Chester Siler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1703 Kendall Gate Way, Bel Air, Maryland 21015 Michael Siler / Son 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ₺ Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place) 7/29/2011 4 ☐ Donation 5 ☐ Other (Specify) Air Memorial Gdn. Bel Air, Maryland of Fun Service Lice 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ AtherocleRotic CARLIBVASCU en year Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to for as a consequence of, Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed' 2 **N**O 1 Yes Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗆 No မ 1 X Yes 1 Inpatient 2 K ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 \square Pending 1 🔀 Natural work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A 2 Accident
3 Suicide
4 Homicide Investigation completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🛱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 [3 [Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day. Year)

State Registrar 31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 9

NORTH

d35522

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Je30 Physician/ derio Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Overlea Health & Rehab Center Baltimore 8. Date of Birth (Month, Day, June 11 5. Social Security Number 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Year) 921 Hours Min. 1**X** XM 2 □ F Months Country) Maryland 90 Director June 215-03-6992 Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show jury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location Director XX Yes 2 ☐ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6116 Belair Rd. 21206 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1XXYes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2XXNo Specify 3 Widowed 4X Divorced WW II White Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) Statistician Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Sara Marsiqlia John J. Serio, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9500 F Amberleigh Lane, Perry Hall, MD 21128 Marquerite S. Serio Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State New Cathedral
Cemetery XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or 4 Donation 5 Other (Specify) 7/30/11 Baltimore, MD Signature of Funer I Se Me Livense 22. Name and Address of FacilityEckhardt Funeral Chapel P.A. 11605 Reisterstown Rd. Owings Mills, MD21117 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac in respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Due to (or as a consequence f) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 45 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi sona that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) Pregnant at time of death 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 😿 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ŴNo 24a. Was an autopsy performed? Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 NiNo မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Sulcide
4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of 29c. License number certifie 29d. Date signed (Month, Day Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 (7005)

State

Registrar

31 Date filed (Month, Day, Year,

BLVd B 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day Physician/ Schultheis, Jr. 10:15P M Walter Ju₁v 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 233 Ashwood Road Baltimore Dundalk . Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth Funeral Month, Day, Year)
an. 20,1919 Months Days Min 1 XM 2 □ F 92 Yrs. Maryland Director 218-05-4097 Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Dunda1k 1 Yes 2X No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 233 Ashwood Road United States 21222 12. Was Decedent Ever in U.S. Armed Forces?
1 ▼Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 1 XYes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: 3 X Widowed 4 □ Divorced White Year or Dates. WWII 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Pipefitter Western Electric Co. 7 Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mildred Emily Gray Walter D. Schultheis, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1002 Boxwood Drive Hampstead, MD 21074 Mrs. Diane Tuminello(Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Oak Lawn Cemetery 7/25/2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 21. Signature of Funeral Service License 7922 Wise Ave. Dundalk, Marvland Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or s consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Desity for as a consequence cry. Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 68760 phys the b IE EEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Box (in the past 12 months? Year 1 Yes 2 9 Unknown a 🗌 Unknown P.O. signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 1 ☐ Yes 2 ☐ No Yes 2 Be 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) Hospital. Other: 2 No ြု 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide injury 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: Ai completed filled in by the fu Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 — Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 25 Day 201°1 2:50A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Cecil Co. Calvert Manor Health Care Ctr. Rising Sun Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Dec. 17,1923 1 🗆 M 2 😾 F Min. Hours Virginia Director 87 219-16-3063 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Rising Sun MD Ceci1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21911 202 Stone Run Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married ģ Yes 2 No 1 ☐ Yes 2X No Specify: If Yes, Give 3 Widowed 4 Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Crown Cork & Elementary/Seconday (0-12) College (1-4 or 5+) Seal Corp. Manufacturing 12 Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Sarah Lucus William Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 202 Stone Run Drive Rising Sun, Maryland 21911 Lorretta Lynch (Daughter) 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Meadowridge Mem. Cem. 7/29/2011 Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Edneral Service Licensee Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between and Death Immediate Cause (Final IRDS EPSI Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** WEEK Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami Due to (or as a consequence of) resulting in death) Last physician the burial Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Pregnant at time of death certificate has been signed by the rector, page 2 should be detached q 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? Natural 5 Pending iniury 2 No Investigation Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature 29c. License number ompleted cause of death (Item 23a) (Type, Print) 30. Name and address of person w 281

Registrar DHMH 17 Rev 7/2009

State

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

10

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 24214 Certificate of Death Reg. N 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month SIMPSON C DOROTHY 505 AM Medical 201 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Glen Meadows Glen Arm Baltimore 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Funeral 8. Date of Birth 9. Birthplace (State or Foreign Months May 11, 1 🗆 M 2 😾 F 93 Year 918 219-01-3219 **Director** Marvland Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director Maryland Baltimore 1 🗌 Yes 2 💢 No Baltimore 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral th and Mental Hygiene. 27 is marked other than "natural", or items 23s traumatic event, the Medical Examiner must I 1122 Overbrook Road 21239 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black White etc Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Specify: 3 X Widowed 4 Divorced Year or Dates. White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be pe filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ Louis Light Louisa Roche and 2 should b Health and Mer tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeffrey Frankenfeld/GreatNephew 5300 Myers Orchard Way Perry Hall, Md. 21128 Department of Healtl Important: If item 2 any injury or other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Page 1 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/29/2011 Moreland Cemetery Baltimore, Maryland 21. Signature of Faneral Schrife Licens 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home, Inc. Towson, Md. 21204 dations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ie cause on each line. 23a. Part 1. Enter the disease, of shock, or heart failure. List Approximate Interval Between Immediate Cause (Final O et and eath Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence or To the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and deep detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by EMENTA 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an after death.

Director: After this certificate has autopsy performed? 1 Yes 2 No 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Certificate: To 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide City or Town, State) within 24 hours To the Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Cortifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number A-CAS

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day 2011 July 27, Physician/ 7:46 P M Stewart Μ. Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Baltimore Towson Gilchrist 9. Birthplace (State or Foreign Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Age (In vrs. last birthday) Days Hours 12/7/1919 1 🗆 M 2 🗶 F Min. 219-01-6596 Marvland Director 91 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Timonium 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 36 Talbott Ave. 21093 U.S.A. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc P à 1 Never Married 2 Married ☐ Yes 2 🛣 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White "natural" Completed 3 X Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Anna Williams J. Edgar Robinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 36 Talbott Ave. Timonium, Maryland 21093 Phyllis Morrow / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Dulaney Valley Mem. 8/3/2011 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ propable metastatic disease or condition menown Medical resulting in death) Tue to (or as a consequence of): Examiner Cequentiary fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Exami g physician and is the burial-trans Due to (or as a consequence of): Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 mon Month Day Pregnant at time of death
Unknown 5 Other (specify) 1 ☐ Yes 2 ☐ 9 ☐ Unknown 2. No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown cate has been signated by page 2 should by 24a. Was an Were autopsy findings available prior to completion of cause of autopsy perform death? within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Ho spr Ze 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 🚅 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

Registrar
DHMH 17 Rev 7/2009

30. Name and address of person who complete

Parte

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32. Regis

eause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien

			1 - For State Registrar	State of IVI	aryiand		tificate of L	eaith and iv Death		eg. No.	24216
	Physicia		Decedent's Name (First, Middle AARON	e, Last) SMELK	TNSO	V			2. Date of Deat Month JULY 2	h 27, Day 2011	3. Time of Death 2:20 A M
	Medic Examir		4a. Facility Name (if not institution		TIOOI		4b. City, Town, or	Location of Death	OCDI Z	4c. County of De	
-,1	<u></u>		WEINBERG PARK		VING		BALT	IMORE		N/A	
	Funeral Director		5. Social Security Number 218-14-8488	6. Sex 14 M 2 D F	e (In yrs. Ia 103	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 05/08/	,Yea <i>r</i>) 9. E	Birthplace (State or Foreign Country) MD
	nd thow	۱,	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Loc	ation				10d. Inside City Limits
	Aaryla 8a-f s tified	ect	MD N/A			BALTI	MORE				1 X Yes 2 ☐ No
	the A		10e. Street and Number				10f. Zip Code		1	l 0g. Citizen of What 0	Country?
	n with	Funeral Director	5833 PARK HEI	GHTS AVENUE,	#204	4	212	215		USA	
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Mar 3 ☑ Widowed 4 ☐ Divorced	If You Give	ver in U.S. No		/as Decedent of Hi Yes, specify Cuba ☐ Yes 2 🛣No	spanic Origin? (Spe n, Mexican, Puerto Specify:	cify Yes or No- Rican, etc.)	Black, Wh	nerican Indian, lite, etc. WHITE
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Mar	2 shou Ith and 27 is m traum		19a. Informant's Name/Relations SHERRY BERNSTEI		משחו		•	nd Number or Rura		City or Town, State, 2	Zip Code) 208
ē,	of Heal fitem		20a. Method of Disposition		20b. Pla	ace of Dispos	sition (Name of			20c. Location - City	
<u>E</u>	Page nent o ant: If ury or		1 🔀 Burial 2 □ Cremation 4 □ Donation 5 □ Other (S	3 ☐ Removal from State Specify)		-	atory or other plac ION CEME		8/2011	BALTIMORE	• MD
Baltimore,	permit. Departn Importa any inju	1	21. Signature of Funeral Service I	icensee	0		Name and Address			ON & BROS	
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-~. <u>[</u>	Physician/		23a. Part 1. Enter the disease, or shock, or heart failure. List o Immediate Cause (Final disease or condition	only one cause on each line	the death			such as cardiac of		st,	Approximate Interval Between Onset and Death
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	requires that the death certific been signed by the attending should be detached for use as	by Physician/N	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live Birth 4 Pregnant at 9 Unknown			Ectopic pregnanc Other (specify)	у		Month	Day Year
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ord D	5 0001	Completed	Y						24a. Was an		autopsy findings available
ž	Physician: The law r this certificate has ral director, page 2 s	Com							autops perforn 1 \(\sum \) Yes 2		
<u>ra</u>	ician: certific ector,	Be	25. Was case referred to medical examiner?	Hospital:				ice of Death (Check	only one)	,	
<u>></u>	Physic ruthis caral dir	5	1 L Yes 2 No 27. Manner of Death			R/Outpatient	3 DOA Othe	4 L Nursing Ho	me 5 Resider	nce 6 Other (Spe	ecify) NSSUSTED
u C	ath. r: Afte re fune	icate	1 Natural 5 Pendin 2 Accident Investig	g (Month, Day		injury	work'	Yes 2 \(\sum \) No	zed. Describe nov	w injury occurred	MINIE
Division of Vital Records,	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Certificate	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ			ne, farm, stre	et, factory, office		28f. Location (Str. City or Town,	eet and Number or R , State)	ural Route Number,
<u> </u>	lospita 4 hours uneral ed filled	Medical	29a. Certifier 1 Certifying (Check 2 Medical E	Physician: To the best of examiner: On the basis of ex	ny knowle	dge, death o	ocured at the time,	date and place, and	d due to the caus	se(s) and manner as s	stated. e cause(s) and manner stated.
	Fo the Printing of the Fromplet	Me	29b. Signature and title of certifier	Norse Practioner To the t	GO CO	the Month	29c. License	three, date and place	e, and due to the a	Pd. Date signed (Mon	w etotad
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			30. Name and address of person v	who completed cause of de		a - 1 - 1	int) P	A 1116	PIL	-TIMOR	e.m.D-
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			For State Registrar	State of	Maryland		artment <i>tificat</i> e					Reg. N2 (110	24217
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	Funeral		5. Social Security Number 6.	Sex 7.	Age (In yrs. la		If Under Months		If Under	r 24 Hrs. Min.	8. Date of Birt (Month, Da	th v. Year)	9. Birth Cou	place (State or Foreign
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	h the	Director	10e. Street and Number				10f. Zip-					10g. Citizer	of What Cou	ntry?
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	er dez items ier mu	Funeral	11. Marital Status 1 ☐ Never Married 2 ※ Married	12. Was Decede	9 5 ?	3. 13. \	Was Decede f Yes, speci	ent of His ify Cubar	spanic Or n, Mexica	rigin? (Spe n, Puerto I	cify Yes or No- Rican, etc.)	. 14.	Race - Amer Black, White	
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Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	၉	19a. Informant's Name/Relationship	(Type. Print)		19b. Mailir	ng Address	(Street a			al Route Numb	er, City or T	own, State, Z	p Code)
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Ĕ	Pages tment of I tant: If Ite		4 ☐ Donation 5 ☐ Other (Spec	rify)		STVIEW					1-2011	SOUTH	HILL,	VA
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Lice	Table (WI 12	LLIAM 206 W.	I Addres I C. NOI	s of Facil BROW RTH A	ity VN FU AVE	NERAL H BALTIMO	IOME P	A. D 2121	7
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Division of Vital Records, P.O.	Hospital or Attending Physician: The law requires that the death certificate hours after death. 24 hours after death. 24 hours after death. 25 hours after death. 26 hours after death. 27 hours after death. 28 hould be detached for use a stell filled in by the funeral director, page 2 should be detached for use as	by	Part II. Other significant conditions	contributing to deat	th but not resu	ulting in the u	underlying o	ause giv	en in Par	t I.	23e. Did t		ocontribute to	the cause of death? obably 4 Unknown
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a E	yslcian: The I. s certificate ha director, page		OF Man and referred to madical			_			00 PI		_		1 🗌 Yes	2 🗌 No
Ξŧ	slcian: Th certificate irector, pa	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Vian	atient 2 🗀 E	ER/Outpatien	t 3 🗆 DO	Othe	r.		(Check only one 5 ☐ Residue)		Other (Spec	ify)
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) ivi	To the Hospital or Attend within 24 hours after death To the Funeral Director: / completely filled in by the	Certification:	3 Suicide 6 Could not 4 Homicide determine		injury - At hor , etc. <i>(Specify)</i>	me, farm, stre)	eet, factory,	office			28f. Location(City or Tov		Number or Ru	ıral Route Number,
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D.	To the Hospital within 24 hours a To the Funeral C completely filled	edical	(check only 2 Medical Ex	aminer: On the basi and manner		ion and/or in	vestigation,	in my o	pinion, de	eath occur	ed at the time	, date and p	place, and due	e to the cause(s)
	To th Comp	M	29b. Signature and title of certifier	01				License				29d. Date s	signed (Month	, Day, Year)
	/		Mirela	54	MO/P			-62	55			July	J 27	, 2011
	5		30. Name and address of person whe MIRNELA BY		of death (Item	23a) (Type,	Print)		40	940 F:	stern A	venue	Baltimo	ore, MD, 21224
	Sta	ite	31. Date filed (Month, Day, Year)	32 legi	strar's Signatu	2 7			7.		J.J.			,, _ 1227
	Registr		JUL 292	011 2	un to	7. 400	week							

DHMH 17 Rev 1/2001 11595

trick Travers		State of Maryland / Department	artment of Healtl ertificate of Death			2011 g. No.	24218
Physici edical Exam	an/				Date of Death Month	n Day Year	3. Time of Death 0536 hrs
sulcai Exam	IIICI	4a. Facility Name (if not institution, give street and number)	4b. City, To	own, or Location of De	July 24, 20 eath	4c. County of Death	
		7731 Norfolk Road	Glen B		ALL- TO Date of Birth	Anne Arundel	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. 24)	last birthday) If Under Months		Min. 6-16-1	CO 7 Foreign	
and f show any once.	ō	3.00	, Town or Location Slen Burnie				10d. Inside City Limits 1 Yes 2 X No
teath with the Maryland items 23a or 28a-f show any tust be notified at once.	I Director	10e. Street and Number 7731 Norfolk Road	10f. Zip (21060		g. Citizen of What Coun USA	
2 5 8	y Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year	If Yes, specify	t of Hispanic Origin? Cuban, Mexican, Pu No specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - Americ White, etc.	
11215-0036 lid be filed within 72 hours after Aental Hygiene. aarked other than "natural", event, the Medical Examiner	ted by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	16a. Decedent's Usual C during most of work	ccupation (Give kind ing life. DO NOT use		16b. Kind of Business/Ir	ndustry
036 vithin 7 en e. er than Medica	Completed	12	Carpen			Carpentry	
215-(be filed a stal Hygi ked oth ent, the	Be C	17. Father's Name (First, Middle, Last) Anthony James Travers Sr.			ame (First, Middle, M eryl Conno	· ·	
MD 21; 2 should be the and Men 27 is mar	101	19a. Informant's Name/Relationship (Type, Print) Mrs Cheryl Travers/mother			or Rural Route Numb en Burnie	per, City or Town, State, MD 21060	Zip Code)
nore, lages I and nt of Heal		1 Burial 2 X Cremation 3 Removal from State	Place of Disposition (Name crematory or other place) tro Cremator		Date 7 / 28 / 2011	20c. Location - City or T	
laitin rmit. Pa epartmes aportan jury or		21. Signature of Funeral Service Licensee		,	' '	iddick Fune	
Physician		MO 1 3					Approximate Interval
/Medical Examiner		failure. List only one cause on each line. Immediate Cause (Final disease a. Asphyxia					Between Onset and Death
		or condition resulting in death) Due to (or as a consequence of b. Hanging	of):				
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated c					
nted ransit	Exa	events resulting in death) Last Due to (or as a consequence of d.	of):				
50, te be executed sysician and burial - transit	edical	UNPENDED AMENDED					
OX 6876 eath certifica attending ph	2	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnant in the past 12 months? 23c. If yes, outcome of pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	2 Fetal death	3 Ectopic pre	egnancy	23d. Date of delivery Month Da	yay Y ear
P.O. B ss that the de gned by the		Part II. Other significant conditions contributing to death but not in	resulting in the underlying c	ause given in Part I.		pacco use contribute to the	
Is, P.(quires that en signed ald be det	ted by				1 Yes	2 No 3 Proba	ably 4 Unknown
Division of Vital Records, ral or Attending Physician: The law requirers after death. 11 Director: After this certificate has been siled in by the funeral director, page 2 should be	Completed				autops perform 1 Yes 2	y prior to co ned? death?	ompletion of cause of
Vital Revision: The his certificate director, page	o Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2	ER/Outpatient 3 DO	Other Nu		Residence 6 🗸 Other:	Scene
On of \ cending Physath. or: After the funeral	-	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year) Jul 24, 2011		lc. Injury at Work? 1 Yes 2 ✔ No	Subject hand	ow injury occurred ed self	
Division or Att hours after de Inneral Direct y filled in by	Certification:		nome, farm, street, factory, o mily Home	office building, etc.	or Town, Sta	reet and Number or Rurate) oad,Glen Burnie,M	_
To the Hosp within 24 ho To the Fune completely fu	Medical C	29a. Certifier (Check only one) 2 Medical Examiner: On the best of my knowled and manner stated.					
F 3 F 8	Me	29b. Signature and fitle of certifier		License number O.C.M.E.		29d. Date signed (Moni July 24, 2011	th, Day, Year)
2		30. Name and address of person who completed cause of death (Iten Pamela E. Southall, MD Assistant Medical Exa		imore Street, Ba	altimore, MD 21	223	
	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	ure				
Regis	_	30L 29 2011 Janua S. A.	COMPONIAL				
CME 2006			OTHER		1	JOME	

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

On the of Manyland / Department of Health and Mental Hygiene 2011 24219 Lawrence Michael Udzinski 1- For State

		Registrar	or Boatin		eg. No.
Physic ledical Exam				2. Date of Deat Month July 25, 20	Day Year 1530 hrs
		La. Facility Name (if not institution, give street and number) Upper Chesapeake Medical Center	4b. City, Town, or Location of Dea Bel Air	th	4c. County of Death Harford
Funeral Director		5. Social Security Number 214-72-5790 6. Sex 7. Age (In yrs. last birthday) Usual Residence of Decedent	If Under 1 Year If Under 24H Months Days Hours M		th(MM/DD/YYYY) 9. Birthplace (State or , 1958 Foreign Baltimore, Country Maryland
viaryland 28a-f show any 1 at once.		10a. State 10b. County 10c. City, Town or Loc MD Baltimore Balti			10d. Inside City Limits 1 Yes 2 XNo
ath with the Maryland tems 23a or 28a-f sho st be notified at once.	Director	10e. Street and Number 6022 Marquette Road	10f. Zip Code 21206	10	og. Citizen of What Country? United States
after de al", or i	d by Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year or Dates:	Vas Decedent of Hispanic Origin? (Yes, specify Cuban, Mexican, Puer Yes 2 No specify: ent's Usual Occupation (Give kind o	to Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White 16b. Kind of Business/Industry
215-0036 be filed within 72 hours ntal Hygiene. ked other than "natur ent, the Medical Exam	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) Qual.	most of working life. DO NOT use re ity Control Ted	nician	Beverage Capital
D 21215-00 should be filed wit and Mental Hygien 7 is marked other natic event, the M		Charles Anthony Udzinski, Sr.		ne (First, Middle, M ca Cecelia	a McCabe
nore, MD 2121. ages 1 and 2 should be file that of Health and Mental 1 it: If item 27 is marked other traumatic event,	욘	Judy Udzinski- Wife 602	2 Marquette Road	l, Baltimon	re, Maryland 21206 20c. Location - City or Town, State
Baltimore, MI permit. Pages 1 and 2 s Department of Health as Important: If item 27 injury or other traum.		1 Burial 2 X Cremation 3 Removal from State EVAILS or Chapel	#uneral Ji -Bel Air	11y 31, 2011	Forest Hill, MD
		23a. Part 1. Eriter the disease, or complications that caused the death. Do not enter	Name and Address of Facility Vans Funeral Che 800 Harford Road the mode of dving such as cardiac	, Parkvill	ie, Maryiano 21234
Physician /Medical Examiner		failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a Drowning complicated Due to (or as a consequence of):			Between Onset and
	iner	Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause			
cuted ind transit	I Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.			
760, cate be execut physician and	an/Medical	X UNPENDED AMENDED 23a, pt.II, 27, 2 IF FEMALE: 23c, If yes, outcome of pregnancy	8a-f,per me,g918	8-17-11	STD 23d. Date of delivery
Box 68760, he death certificate be the attending physici ned for use as the buri	Physician/	23b. Was decedent pregnant in the past 12 months?	etal death 3 Ectopic pregr Other (Specify)	ancy	Month Day Year
ires that the signed by the detached	by	Part II. Other significant conditions contributing to death but not resulting in the Alcohol and Phencyclidine use	underlying cause given in Part I.	23e. Did tob	pacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown
cords law requires been been calculated as a should	Completed			24a. Was a autops perform	prior to completion of cause of death?
Vital Representations: The this certificate director, page	To Be (25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpatien	26.Place of Death (Check of 3 DOA Other Nursi		Residence 6 Other:
On Of ending Pl sath. or: After the funeral		27. Manner of Death 1 Natural 5 Pending 2 X Accident Investigation 1 Page 1 Page 2 Pa	1 Yes 2 X No		ow injury occurred drowned
Divisi E Hospital or Att 124 hours after de Funeral Direct etely filled in by	Certification:	3 Suicide 6 Could not be determined (Specify) found in poor	eet, factory, office building, etc.	28f. Location (Story Town, Starks) Bel Air,	reet and Number or Ryral Route Number, City ate) 3007 Woods End Dr.
To the Hospital within 24 hours To the Funeral completely filled	Medical (29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.			
JOH S	Me	29b. Signature and title of certifier	29c, License number O.C.M.E.		29d. Date signed (Month, Day, Year) July 26, 2011
1 horde		30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 900 W. Baltimo	ore Street, Baltimore, MD 2	1223	
Si Regis	tate	31. Date filed (Month, Day, Year) 32. Fighthed's Signature	. 4.1		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 24220 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Kosta Peter Vlahacos Medical 2011 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Doctors Community Hospital Lanham Prince George If Under 1 Year Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □XM 2 □ F Hours Mary land Director 215-74-6346 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director Clarksville Maryland Howard 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 5645 Trotter Road 21029 U.S.A. death v 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. "natural", or 1 Never Married 2 X Married Page 1 and 2 should be filed within 72 hours after Yes 2 XNo Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hours pepartment of health and Mental Hygiene. Important: If Item 27 is marked other than "natur any Injury or other traumatic event, the Medical I 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) NASA Physicist 5+Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Peter **Vlahacos** Evangelia Kosmakos 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5645 Trotter Road Clarksville, Maryland 21029 Sophia I. Zanakos / Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Greek Orthodox Cem 1 X Burial 2 Cremation 3 Removal from State 7/30/2011 Woodlawn, Maryland 4 Donation 5 Other (Specify) any inj 21. Signatur pera Service L 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician. Cardio respuntatoro Due to (or as a consequence in): disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or iinjury myo card Acute burial-trans that initiated events resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death Day signed by the at d be detached for g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ encephal 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Acute renal 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy death? After this certificate 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 Yes 2 No Investigation Accident s after deat Director: Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Funeral Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier within 2 To the F 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier

State Registrar FFICE

32. Registrar's Sig

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 0 Month Physician/ 20111 11:30A M Richard Patrick Williams Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Joseph Ritchie Baltimore N/A 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 ☐ F Months Days Hours Min. 1272471959 Maryland 219-76-3998 51 **Director** Usual Residence of Decedent show or 28a-f shov notified at 10b. County 10d. Inside City Limits 10a, State within 72 hours after death with the Maryland 10c. City, Town or Location Director 1. Yes 2 □ No MD N/A Baltimore 10e, Street and Number ō 10f. Zip Code 10g. Citizen of What Country's Iral", or items 23a or Examiner must be Funeral 3408 Hilldale Place 21215 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14 Race - American Indian. Black, White, etc. 1 X Never Married 2 Married Completed by ☐ Yes 2x No Maryland 21215-0036 If Yes, Give Year or Dates. 1 Yes 2 No Specify: Specify: Black "natural". 3 - Widowed 4 - Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) ntary/Seconday (0-12) College (1-4 or 5+) Elementary/Seconday (0-1 12th Grade Laborer Sanitation Co. permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important; If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Richard Patrick Williams Sr. Barbara Lee Anderson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $2\,1\,2\,4\,4$ 19a. Informant's Name/Relationship (Type, Print) Wayne Williams (brother) 7406 Lesada Dr. Apt 1A, Windsor Mill, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2XX Cremation 3 Removal from State on-site Crematory 07/26/11 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses For Find Has of Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ netestures disease or condition Medical resulting in death) Examiner 2011 Sequentially list conditions, Examine Du lo (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live Birth
4 Pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? be detached for Month Dav Year Pregnant at time of death Yes 2 No the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Director; After this certificate 2 🗆 No 1 Tes 2 💆 Yes Hospital or Attending Physician: 24 hours after death. Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \(\to \) Nursing Home 5 \(\to \) Residence 6 \(\to \) Other (\$\frac{1}{2}\$ 1 Yes 2 No Certificate: To 1 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpa of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 Natural 5 Pending work' Division 1 Tyes 2 🗌 No Investigation 6 Could not be Accident Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 11 erson who completed cause of death (Item 23a) (Type, Print) 2

State Registrar JUL 2 9 2011

7

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 24222 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ^D2011 Ronald Anthony Woodward July 26, 8:50 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Montgomery Suburban Hospital Bethesda 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Months Hours 1 XM 2 - F Mary Land 67 Yrs. T944 **Director** 220-40-8485 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Maryland 1 Yes 2 X No Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 5005 West Cedar Lane 20814 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian rmed Forces? Black, White, etc. ð 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 Yes 2 X No Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16h Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Medical Billing Elementary/Seconday (0-12) College (1-4 or 5+) Office Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Anton Matejovic Irene Lachoski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tipaporn A. Woodward/Wife 5005 West Cedar Lane, Bethesda, Maryland 20814 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State July ^D29, cemetery, crematory or other place)
Montgomery
Crematorium.Inc. 1 Burial 2 🔀 Cremation 3 D Removal from State 2011 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ 21. Signature of Funeral Service Licenses Bethesda-Chevy Chase Inc. Bethesda, Maryland 20814 7557 Wisconsin Avenue M01498 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ Non-Small Cell Lung Carcinoma Medical resulting in death) Due to (or as a consequence of) **Examiner** Congestive Heart Failure Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Neutropenic Fever attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Septic Shock 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year 1 L Yes 2 L 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 autopsy performed? 1 ☐ Yes 2 ☐ No Yes 2 🔀 No Hospital or Attending Physician: Vital funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🕱 No မ 1 x Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Division of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending s after death. Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours
To the Funeral Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one) ē 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) July 26, 2011

Registrar DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Siddharth Bethi, MD

29

31. Date filed (Month, Day, Year)

D68637

8600 Old Georgetown Road, Bethesda, Maryland 20814

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 7 Donna 4:47 PM Wirtanen Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore of Maryland Medical If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthdav **Funeral** 1 🗆 M 2 🔀 🛱 Days Hours 11/16/1949 MaryTand Director 212-50-5574 61 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10d. Inside City Limits 10c. City, Town or Location Director Maryland Harford Bel Air 1 Yes 2xXNo 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? **Funeral** 1309 J Scottsdale Drive 21015 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 XMarried Yes 2xxNo Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: white 3 Widowed 4 Divorced Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Manager Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Alvin A. Phillips Maryann Rudisill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) G. Neale Wirtanen (husband) 1309 J Scottsdale Dr., Bel Air, MD 21015 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a Department of H Important: If ite any injury or ot cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) R.A. Ferris & Company 7/28/2011 West Chester, PA 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen, MAryland 21001 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Due to (or as a consequence of) Bacilli disease or condition Medical resulting in death) Examiner Sequentially list conditions Examiner Due to (or as a consequence of) if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Year Pregnant at time of death certificate has been signed by the rector, page 2 should be detached g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 XNo Hospital Other: 1 🗌 Yes 은 within 24 hours after death.

To the Funeral Director: After this 1 Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Accident 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in rity opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 1710286935 2011

State Registrar South Greene St.

Baltimore, MD 21201

M.D

egistrar's Signatu

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 9 2011

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State AMEND #19b, PER FH, QACHD, MS, 7/15/1 Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 201 T JULY 9:15 \mathbf{P} M MARY G. ALLEN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** QUEEN ANNE'S QUEENSTOWN 223 OVERLOOK DRIVE Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** WASHINGTON, DC Hours MAY 10, 1935 212-34-2307 76 Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10d. Inside City Limits 72 hours after death with the Maryland 10c, City, Town or Location Director QUEEN ANNE'S MD QUEENSTOWN 1 Yes 2 X No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? ō ems 23a or must be r Funeral 21658 USA 223 OVERLOOK DRIVE 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No "natural", or iter ledical Examiner r 14. Race - American Indian. Armed Force Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 Never Married 2 Married þ Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: Specify: Completed 3 Widowed 4 X Divorced WHITE Il Hygiene. I other than "natura vent, the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other that any injury or other traumatic event, the once. COMPUTER PROJECT CONTROLLER 12 2 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ ELIZABETH DOUGLAS GEORGE C. GRAFF 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1656-TRAWLER-COURT, ANNAPOLIS, MD 21401 DEBORAH BENNETT/DAUGHTER 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State HILL CREST CEMETERY JULY 16, FEDERALSBURG, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Sig/ tur/ Funeral Service 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A.
06 SHAMROCK ROAD, CHESTER, MD 21619 numero 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ UNG CANCER YEAR disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last and the burial-trar Due to (or as a consequence of) attending physician Physician/Medical as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Year Month Day 5 Other (specify) Pregnant at time of death signed by the a No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 this certificate has within 24 hours after deatl To the Funeral Director:

funeral director,

filled in by

Be

၉

Certificate:

Medical

Hospital

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 4 201

28a. Date of injury

(Month, Day, Year)

8221 TEAL DRIVE, SUITE 302, EASTON, MD 21601 DAVID H. SMITH, M.D., 31. Date filed (Month, Day

1 Inpatient 2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

State Registrar

25. Was case referred to medical

5 Pending

Investigation

Could not be

determined

examiner?

1 Yes

Manner of Death

Natural

Accident

Suicide

4 Homicide

29a. Certifier

(Check only one)

29b. Signature and titl

Yes 2

28d. Describe how injury occurred

5 Residence 6 Other (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

-13-2011

26. Place of Death (Check only one)

4 Nursing Home

Other:

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

28c. Injury at work?
1 Yes 2 No

☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated ☐ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D39887

29c. License number

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 20<u>11</u> **Physician** 11:30 A.M William . Watson Allen July 12, /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Solomons Nursing Center Calvert Solomons If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 □ F Director 09/05/1934 577-46-2802 76 Washington, Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10h. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show or other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Completed by Funeral Director Calvert Sunderland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 "natural", or Items 23a U.S.A. 5721 Hardesty Road 20686 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 MYes 2 No
If Yes, Give
Year or Dates: 1957-59 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No 3 ☐ Widowed 4 ☐ Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If item 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) plumber Plumbers Union Local 5 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Watson Allen Marv Frances 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health at
Important: If item 27 is
any Injury or other trau William A. Allen, son 8986 Chesapeake Lighthouse Dr., North Beach, MD 20714 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 07/13/2011 Alexandria, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 20736 23a. Part 1. Enter the dise, se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failur. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ESOPHAGEAL Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of Hospital or Attending PhysIclan: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 ☐ Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed' 1 □Yes 2 ☑No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manper of Death 28b. Time of After 1 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death

To the Funeral Director:
completely filled in by the 1 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 🗺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

6+1

State Registrar

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/200

[wish

32. Registrar's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

GYAN

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month -Physician/ 30,0M Medical Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death Sounty of Death Examiner Par Severna Tru acc If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, 1 M 2 X F Months Hours Country) Kentucky 87 Director 405-24-0983 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Pasadena MD Anne Arundel 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral USA 1092 Notley Court 21122 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: marked other than "natural" Completed 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Westinghouse Inspector Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lou Ellen Hogg Lincoln Coldiron 19a. Informant's Name/Relationship (Type, Print) .. Page 1 and 2 shoutment of Health and tant. If item 27 is m 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1092 Notley Court Pasadena, MD 21122 Joyce Rechner / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State July 14 2011 permit. Page 1 Department of I Important: If it any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD Veterans Cemetery Crownsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Ritchie Hwy, Severna Park, MD 21146 23a. Part (Enter the dicease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final) Physician/ disease or condition resulting in death) Medical Due to (or as A consequence of Examiner Sequentially list on utilities if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d Date of delivery in the past 12 months? Day 2 🗌 No 9 Unknown signed by the Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 3 Probably 4 Unknown 1 Yes 2 🗌 No Completed certificate has been si irector, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 19 0 2 X No 1 Yes director, 25. Was case referred to medical examiner?

1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital Other: မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Director; After this in by the funeral dir 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 X Natural 5 Pending 2 🗆 No Acciden
Suicide Accident Investigation Director; Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours aff

To the Funeral Di

completed filled in Medical 🙎 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number

State

Registrar

Tidewater (olany Dr. #1A

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

This is a completed cause of death (Item 23a) (Type, Print)

1 4 201

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend #10c perFH, FCHD, 7/14Qertificate of Death LE 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 STEVEN ROBERT BEVERAGE Julj Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Memorial Frederick Hospital If Under 1 Year If Under 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 🛛 M 2 🗆 F Months Days Hours Min (Month, Day, Ye NewYork 63 212-52-2742 Nov 1947 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10d. Inside City Limits Director Passadena Pasadena Anne Arundel 28a-f Maryland 1 Yes 2 No 5 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21122 8413 Alvin Road USA 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc "natural", or Completed by 1 Never Married 2 Married 1 X Yes If Yes, Give 2 🗌 No Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: Specify: 3 Divorced 4 Divorced Year or Dates ed other than "nature event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) US Coast Guard sheet metal worker is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Veronica Durkin Donald Beverage 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21710 2312 Pleasant View Road, Adamstown, Maryland Donald Beverage - brother injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of Important: If it any injury or or one one cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Stauffer Crematory 7-13-2011 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stauffer Funeral Home 21. Si ture of Funeral Service Licensee 21704 anie 1621 Opossumtown PIke, Frederick, Maryland Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph_sician/ romally orders disease or condition Medical resulting in death) Éxaminer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to r as y physician and is the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 attending ph for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Pregnant at time of death been signed by the should be detached 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No After this certificate has funeral director, page 2: 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: Certificate: To 1 🗌 Yes 2 No 1 Inpatient 2 FER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending work within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 2 Accident
3 Suicide
4 Homicide 1 🗌 Yes 2 🗀 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check

Division of Vital

Registrar

only one) 29b. Signature and title of certific

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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DHMH 17 Rev 7/2009

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death . Day 20<u>11</u> Physician/ Month July Scott Lauren Barber 12 1:57 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis If Under 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 1 Å M 2 □ Year If Under 24 Hrs. 8 Date of Birth 7. Age (In vrs. last birthday) **Funeral** New York Months 107T071952 Yrs 576-56-2758 58 **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits notified at Director 1 Yes 2 No Anne Arundel Edgewater Maryland 10e. Street and Number 10f. Zip Code ò 10g, Citizen of What Country? must be Funeral items 23a USA 21037 122 Southdown Road hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. event, the Medical Examiner Armed Forces? Black, White, etc. ò 1 Never Married 2 X Married ð Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: "natural", Completed 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) I Hygiene. other than " Anne Arundel Elementary/Seconday (0-12) College (1-4 or 5+) Medical Center Locksmith Carpenter/ and Mental Hygie is marked other vears Be 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Denise E. Harris Robert Churchill permit. Page 1 and 2 should be Department of Health and Men-Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 122 Southdown Road, Edgewater, Maryland 21037 Barbara A. Barber/ Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Edgewater, Maryland 7/14/11 Kalas Crematory 22. Name and Address of Facility George F. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of ying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Betweer Immediate Cause (Final Onset and Death Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last burial-transi and Due to (or as a consequence of): attending physiciar Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 the for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death be detached ed by the Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Unknown 1 🗆 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 autopsy performed 2 (XY)0 Yes the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) 2 1 Yes 2 NO Other: 1 patient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Deat Certificate: 28b. Time of 28c. Injury at work? After Natural 5 Pending 2 🗌 No 2 Accident 1 Yes Investigation within 24 hours after death To the Funeral Director; Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical 29a. Certifie Certifying Physician: The best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gentifying Number Fraction for To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gentifying Number Fraction for To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gentifying Number Fraction for the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gentifying Number Fraction for the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gentifying Number Fraction for the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and the cause(s) and the place of the cause (Check 29b. Signature and file of 29c. License number 201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

StateRegistrar

31. Date filed (Mor

Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 19 Pay Physician/ Month July 2011 Year 2:10 a.M James Elmer Boyce Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **Allegany** Western MD Regional Medical Center Cumberland Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Months Hours 236-14-5864 100 Keyser, WV Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No WW Mineral Keyser 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral White Way Road 26726 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes. Give Specify: 3 🕅 Widowed 4 🗆 Divorced White Year or Dates item 27 is marked other than "natur other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) House Painting and Elementary/Seconday (0-12) College (1-4 or 5+) Wall Paper Installation Self employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Joseph H. Boyce Bertie E. Tusing 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary F. Ours/Daughter P.O. Box 269 Keyser, WV 26726 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Hamportant: If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Potomac Memorial Gardens 2011 Keyser, WV 22. Name and Address of Facility 21. Signature un val Service 85 S. Main Street Keyser, WV 26726 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 4 days shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) theumonia Medical Due to (or as a consequence of Examiner Sequentially list conditions, Examine day leading to immediate cause. Enter Underlying Cause (Disease or iinjury been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? Pregnant
Unknown 5 Other (specify) Pregnant at time of death 2 No 1 L Yes 2 L 9 D Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ₩ No 24a. Was an certificate has autopsy Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To this 28c. Injury at . Manner of Death . Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending work? Natural injury Accident Investigation 3 Suicide 4 Homicide 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir

de

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Christopher Vagnoni, M.D. State Registrar

29b. Signature and title of certifier

WMRMC

Willowbrook Road

29d. Date signed (Month, Day, Year) 7-19-11

Cumberland, MD

		-	For State Registrar	State of Ma	•	oartment of H e <i>rtificate of L</i>			iene _{eg. No} 2011	24230
Н	Physicia	n/	1. Decedent's Name (First, Middle, Last) OWLING	BARNE			2. Date of Death		3. Time of Death
	Medic Examin	al	4a. Facility Name (if not institution, give		DAKNE		Location of Death	חהא	4c. County of Dea	
	-		12751 ARNOLD I 5. Social Security Number 6. Se		PLACE (In yrs. last birthday		OTTE HA	8. Date of Birth	CHARL	rthplace (State or Foreign
	Funeral Director		578-07-1263	☐ M 2 XŪX F	93 Yrs.	Months Days	Hours Min.	JULY 5	7 1918 MA	ARYLAND
	land show dat	1. 1	Usual Residence of Decedent 10a. State 10b. County	I	10c. City, Town or					10d. Inside City Limits
	ne Mary or 28a-1 notifie	Director	MD CHARLES 10e. Street and Number	5	CHARI	OTTE HAL	.L		log. Citizen of What C	1 \(\superstrip \) Yes 2 \(\mathbb{\mathbb{M}}\) No
	n with the rs 23a const be	Funeral	12751 ARNOLD E	BARNETT F	LACE	206	22		U.S.	
980	72 hours after death with the Maryland n "natural", or items 23a or 28a-f show ledical Examiner must be notified at	þ	11. Marital Status 1 □ Never Married 2 □ Married 3€3€36Vidowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☒ N If Yes, Give Year or Dates.		3. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 XX No	n, Mexican, Puerto		14. Race - Am Black, Whi Specify. WHI	ite, etc.
21215-0036	72 hou n "natu Medical	Completed	15. Decedent's Ed (Specify only highest gra	de completed)	(Giv	edent's Usual Occup re kind of work done of DO NOT use retired)		ng	16b. Kind of Business	Industry
212	ifiled within 72 hour tal Hygiene. ed other than "natul event, the Medical	Be Cor	Elementary/Seconday (0-12)	College (1-4 or 5+		E MAKER			AT HOM	iE
lanc	should be filed h and Mental Hy 7 is marked oth traumatic event	To B	17. Father's Name (First, Middle, Last) ARTHUR JOSEPH	MIDDLET	'ON		18. Mother's Name	e (First, Middle, M ETHEL B	,	
Maryland	1 and 2 should be if Health and Men item 27 is marke other traumatic	8	19a. Informant's Name/Relationship (Ty) CHRIS BARNETT	pe, Print) SON	1	-			City or Town, State, Z	Cip Code) 20622 C HALL, MD
ē,			20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □		20b. Place of Dis	position (Name of rematory or other place	LIUT.		20c. Location - City o	
Baltimore,	permit. Page 'Department o Important: If any injury or once,		4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Ligens	9	METRO.			2011 XMOND F	ALEXANDR	VICE, P.A.
Ä	Dep Imp	3	fact Bath	Sels	M00641	5635 WAS	HINGTON	AVE.,L	A PLATA,	MD 20646
,	Physician/		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or Immediate Cause (Final		the death. Do not e	nter the mode of dyin	g, such as cardiac c	r respiratory arre	st,	Approximate Interval Between Onset and Death
	Medical Examiner		disease or condition resulting in death)	aDue to (or as a	consequence of):	edce u	Copac	200	rcs T	
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a	eonscquenes on):	a ce la				
	xecuted	Examine	Cause (Disease or linjury that initiated events resulting in death) Last	c. Due to (or as a	consequence of):					
09,	ate be executed physician and the burial-transit	edical	•	d						
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. On the Funeral Director: After this certificate has been signed by the attending it completed filled in by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome o 1 Live Birth 2 4 Pregnant at 9 Unknown	Fetal death 3	i ☐ Ectopic pregnand i ☐ Other (specify) _	ey		23d. Date of d	elivery Day Year
ds, P.O.	w requires that the second speed by second second by should be detailed.	by	Part II. Other significant conditions co	ntributing to death bu	t not resulting in th	e underlying cause gi	ven in Part I.		es 2 No 3 No	to the cause of death?
Division of Vital Records,	sician: The law re certificate has bo lirector, page 2 sh	Completed	25. Was case referred to medical			ac D	ace of Death /Check		ned? prior to death?	utopsy findings ^l available completion of cause of es 2 No
Vita	Physicia this certi al directo	To B	examiner? 1 Yes 2 No	_	nt 2 🗆 ER/Outpat	ient 3 DOA Oth	or:	. 1	ence 6 🗆 Other (Spe	ecify)
on of	nding P ath. : After t e funera	icate:	27. Manner of Death 1 Patural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day,	y 28b. Time Year) injury	work	yat :? Yes 2 □ No	28d. Describe ho	w injury occurred	
Division	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director After this certific completed filled in by the funeral director,	al Certificate:	3 Suicide 6 Could not be 4 Homicide determined			street, factory, office		28f. Location (Str City or Town	reet and Number or R , State)	ura! Route Number,
	e Hospital 124 hours e Funeral bleted filled	Medical	29a. Certifier (Check 2 Medical Examinonly one) 3 Certifying Nurs		amination and/or inv	estigation, in my opini	on, death occurred at	the time, date and	d place, and due to the	e cause(s) and manner stated.
	To the within comple		29b. Signature and title of certifier			29c, Licens			9d. Date signed (Mon	
	.) b.		30 Name and address of person who c	ompleted cause of de	ath (Item 23a) (Type	BOX 17	3. hal	Plata.	Md 200	546
	Star Registra		31. Date filed (Month, Day, Year) JUL 2 9 2011	32. Registrar	's Signature		7		7	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 24231 State Registrar Amend#11pfh7/20/2011ccdohrb Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 7:50PM Iris (OOK JUY 201 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Prince Georges Brandywine 7110 Accokeek Road Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗶 F Months Days Hours Min 1985 Tennessee 244-46-9834 **Director** ebruary Usual Residence of Decedent 28a-f show and Mental Hygiene.
and Mental Hygiene.
'Is marked other than "natural", or items 23a or 28a-f sho.
"aumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 Yes 2 No Maryland | Prince Georges Brandywine 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20613 USA 7110 Accokeek Road death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married ģ 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White Completed 3 X Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Home Maker permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Iva Sutton Ragan Webb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 166 Westway, Apt. 204, Greenbelt, Maryland 20770 Yvonne Daneri/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Vets' Cem. July 19, 2011 Cheltenham, MD. 21. Sig ... re of Funeral Service Licenses 22. Name and Address of Facility Huntt Funeral Home MON 9@3035 Old Washington Rd. Waldorf, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death COPP Immediate Cause (Final End-Stage Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). burial-transit Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician I for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death signed by the at d be detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has performed 24 hours after death.

Funeral Director: After this certificate Yes 2 funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1 🗌 Yes မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c, Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 🖳 Ćertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MS Rajapalne MID DO057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2835 Smith Au 5-203 21209. CB · Rajapaikse MID Fegistrar's Signature 18 2011 State Barks un Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 24232 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ $1\tilde{3}$ Gerald Andre Covington July 2011 2:42 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Upper Marlboro 301 Singfield Place 5. Social Security Number If Under 1 Year If Under 24 Hrs. . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F Dec. 17 Days Hours 1952 Washington, DC Director 58 579-74-2314 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at rector 28a-f Prince George's Upper Marlboro MD 1X Yes 2 ☐ No ۵ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? be ins 23a r Funeral USA 301 Singfield Place 20774 12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No Navy If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian þ ö 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced Year or Dates ntal Hygiene. ed other than "natura event, the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Mail Sorter Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental F ည Ruth D. Dowd Walter B. Covington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 301 Singfield Place Upper Marlboro, Maryland 20774 S Imogene Covington/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Demoval from State 7/22/2011 Cheltenham, Maryland 4 Donation 5 Other (Specify) Md Veterans Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility J. B. Jenkins Funeral Home, Inc. 7474 Landover Road Hyattsville, Maryland 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Atherosclerosis Medical resulting in death) Due to (or as a consequence of) Examiner Diabetes Mellitus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) as the burial-transit Hyperlipdemia that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Chronic Pancreatitis Box 68760 IF FEMALE: nse 9 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year signed by the a d be detached for 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 ☐ No 3 ☐ Probably 4x Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 27 No 2 🔽 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 □ No ပ္ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 X Residence 6 Other (Specify) filled in by the funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d Describe how injury occurred 24 hours after death. Funeral Director: After the Hospital or Attending 1 🛚 Natural 5 \square Pending work? 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature 29c. License number 2 29d, Date signed (Month, Day, Year) MD14478 July 14, 2011 30. Name and address deperson who completed cause of death (Item 23a) (Type, Print) M.D., 50 Irving Street NW Washington, D.C. 20422 Washington,

DHMH 17 Rev 7/2009

State

Registrar

1 8 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 15^{Day} Harry Quentin Curry July 2011 3:50 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Asbury-Solomons Health Care Center Calvert Solomons Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** Hours 1 № M 2 🗆 F Months Days Min. March 14. Year) **Director** 161-05-9464 91 Pennsylvania Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event; the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo 1 Yes 2 H No Maryland Calvert Solomons 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 11740 Asbury Circle, Apt. 1413 20688 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☑ Yes 2 ☐ No Black, White, etc. 1 Never Married 2 Married \$ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ₺ No Specify: If Yes, Give Specify: White 3 Midowed 4 ☐ Divorced Year or Dates 1942-1945 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Home Builder Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 William Norwood Curry Mildred Cooper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Colleen Mawicke / Daughter 819 Oak Grove Circle, Severna Park, MD 21146 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 A Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 07/15/2011 Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home. P.A. Michael Neven Lusby, MD 20657 Yarden 23a. Part 1. Enter the diseas¹, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Failure to thrive disease or condition Medical resulting in death) Examiner ungestive Mart Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) sician and burial-transit that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Day Pregnant at time of death 1 Yes 2 No ed by the a detached f g 🗌 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ Pheumonia 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a, Was an autopsy certificate ! funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 12 No ပ္ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work / 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or inventioning in an arrival and a state of the cause of examination and/or inventioning in an arrival and a state of the cause of examination and/or inventioning in an arrival and a state of the cause of examination and/or inventioning in an arrival and a state of the cause of examination and/or inventioning in the cause of the Medical

Hospital or Attending Physician: The law requires Records, Division of Vital s after death. 24 hours a To the Hosp within 24 ho To the Fune completed f

Box 68760

10+1 kny

Registrar

29a. Certifier

(Check only one 29b. Signature and title of cer

> John Barth, III, MD 110 Hospital Rd, Suite 310, Prince Frederick, MD 20678 32. Registrar's Signature barks

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

DO052242

29d. Date signed (Month, Day, Year,

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death

10f. Zip Code

4b. City, Town, or Location of Death

20754

Prince Frederick

if Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 01/26/1954

Chick

7. Age (In yrs. last birthday)

10c. City, Town or Location

Dunkirk

57

Joseph

1**∑** M 2□ F

4a. Facility Name (If not institution, give street and number)

Calvert Memorial Hospital

Calvert

9624 Cortland Lane

Month

13

2011

4c. County of Death

10g. Citizen of What Country?

U.S.A.

Calvert

1:30 P. M

DC

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 2 🕅 No

Washington,

July

Physician /Medical Examiner

Funeral

Director

Michael

5. Social Security Number

212-66-2502 Usual Residence of Decedent

10e. Street and Number

10a State

MD

Director

r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. is marked other

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

and burial-trar physician asn for the ģ certificate

Box 68760.

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Division of Vital Records,

Hospital or Attending Physician: The law requires that the death certificate be executed completely filled in by the funeral director, 24 hours after deat • Funeral Director: within 2 To the I ပ္

KW 01

Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 1 □Yes 2 🕅 No Specify Specify 3 Widowed 4 Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) none 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Chick Patricia Smith Clyde Arnold Ann ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau once. 1069 Nash Loop, The Villages, Debra Ann Gray, sister FL32162 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 07/16/2011 Suitland, MD 22. Name and Address of Facility Rausch Funeral Home, P.A. Signature of Funeral Service Licenses 8325 Mt. Harmony Lane, Owings, MD se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause in each line. 23a. Part 1. Enter the dise shock, or heart lilu Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) I ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performe 1 ☐ Yes 2 ☑ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🗹 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Name and address of person who completed cause of death (Item 23a) (Type, Print) , Day, Year) 32. Registrar's Signature State Registrar **ORIGINAL**

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** July 11, 2011 11:00 John Henry Costello /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Chaconia Assisted Living Prince George's Bowie 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthdav) 6. Sex Date of Birth (Month, Day, Year) **Funeral** Days Months Hours Min 1X M 2 □ F 151-28-9006 Yrs. Director 74 New Jersey 12/19/1936 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show if item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Modical Examinat must be notified at 1 XYes 2 No Director MD Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3206 Moylan Dr. 20715 USA by Funeral within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1XYes 2 ☐ No 1 Never Married 2X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: **Korean** 1 ☐ Yes 2XX No Specify: Specify: 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Government permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, Item Is Elementary/Secondary (0-12) College (1-4or 5+) Printing Office Superintendent 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Henry Costello Ruth Metcalf 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1113 Fairlawn Ct., John J. Costello / Son Crofton, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 7/13/2011 4 □ Donation 5 □ Other (Specify) Metro Crematory Baltimore, MD Beall Funeral Home 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 6512 NW Crain Hwy., Bowie, MD 23a. Part1. Enter the disease, or combinations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 0 neavs disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine Due to (or as a nonsequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed burial-trar Due to (or as a consequence of) physician Box 68760 Physician/Medical the attending properties for use as as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) P.O. 9 🗌 Unknown signed by t I be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? cate has by page 2 sl 24a. Was an autopsy performe To the Hospital or Attending Physician: The certificate | 2 1 2 No 1 ☐ Yes director, 25. Was case referre medical examiner? Assisted Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 Yes 2 No After this funeral dir 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Mann Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Vatural 5 Pending hours after death. investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:

completely filled in by the f 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

egistrar's Signature

			ForState	State of Ma	arylan		rtment of H		d Mental	Hygiei	ne		
			Registrar 1. Decedent's Name (First, Middle, Las	24)		Cer	tificate of D	eath	100		No2]	Щ	24237
	Physicia Medio		Laura Ann Collin	•					Mont Jul	of Death h y	Day 20	11	3. Time of Death 2:50 P. M
	Examin		4a. Facility Name (if not institution, give	street and number)			4b. City, Town, or		ath		4c. County of D		
1			4328 Gene Hemp Ro				Jeffer		I		Freder		
	Funeral Director		213-27-6933	ex	e (In yrs. Ia 25	nst birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M		of Birth $12/19$	86 g.	Birthpl Counti	lace (State or Foreign ry) MD
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	arylar a-f sł fied a	Director	MD Frede	and als		Jeffers						"	1 ☐ Yes 2 🗗 No
	or 28		10e. Street and Number	ELICK		rerrers	10f. Zip Code			10g.	. Citizen of What	Count	:ry?
	with t	Funeral	4328 Gene Hemp	Rd.			21755				USA		
	death items ier m	Fun	11. Marital Status	12. Was Decedent E	ver in U.S	5. 13. V	Vas Decedent of His Yes, specify Cubar	spanic Origin?	(Specify Yes o	r No-	14. Race - A		
39	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	d by	1 Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.	No		☐ Yes 2 No		orto riiodii, ott	,	Black, W Specify:	Whi	
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Maryland 21215-0036	be filed ental Hy 'ked oth ic event	To B	17. Father's Name (First, Middle, Last) Todd Collins					18. Mother's N	Name <i>(First, M</i> a Zlon l				
ary	should I and Me		19a. Informant's Name/Relationship (7	ype, Print)		19b. Mailin	g Address (Street a	nd Number or	Rural Route N	umber, City	y or Town, State,	Zip C	ode)
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Baltimore,	e 1 and of Heal If item		20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. P	lace of Disposemetery, crem	sition (Name of natory or other place	e)	Date	200	c. Location - City	or To	wn, State
Ĕ	Pag tment tant: jury c		4 Donation 5 Other (Speci	fy)	Mt.	01ive			5/2011		rederic		
Ba	permit. Page 1 Department of Important: If is any injury or c		21. Signature of Funeral Service Licens	0 0 -	20 r		Name and Address 621 Oposs						es, P.A.
П			23a. Part 1. Enter the disease or comshock, or heart failure. List only of								CIICK		Approximate
	h, si_ian/		Immediate Cause (Final disease or condition			۵ ستر ک	lung c	GACES					Interval Between Onset and Death
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		her	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequ	ence of):						+	
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90	cate be executed physician and s the burial-transit	edical		l d								+	
687	ertific iding p		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	of pregnar	ncy					23d. Date of	dolivo	in/
XOX	eath c atten	icia	in the past 12 months? 1 Yes 2 No	4 Pregnant at			Ectopic pregnancy Other (specify)	у			Month		Day Year
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Division of Vital Records, P.O. Box 687	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transi	by	Part II. Other significant conditions of	ontributing to death bi	ut not resi	ulting in the u	nderlying cause giv	en in Part I.			/		e cause of death?
g	requir been s	Completed	hypoxis						_	Was an			osy findings available
ec	sician: The law certificate has b lirector, page 2 s	duuc							-	autopsy	prior deat	to cor	npletion of cause of
E H	an: The	Be C	25. Was case referred to medical		_		26. Pla	ace of Death (C		Yes 2	INo 1 □	Yes	2 🗷 No
Ĭ	ng Physician: 7 fter this certifics ineral director, p	To E	examiner? 1 Yes 2 To	Hospital: 1 🗌 Inpatie	ent 2 🗆	ER/Outpatien	t 3 DOA Othe	r: 4 🗆 Nursin	g Home 5 🗷	Residence	e 6 🗆 Other (S	oecify)	
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Sion	Attenc death ctor: /	Certificate:	2 Accident Investigatio 3 Suicide 6 Could not be 4 Homicide determined		ry - At ho	me, farm, stre		Yes 2 No	28f. Loca	tion (Street	t and Number or	Rural	Route Number.
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			30. Name and address of person who	completed cause of de	eath (Item	23a) (Type, P	rint)						
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	Stat Registra		31. Date filed (Month, Day, Year) JUL 142	011 32. Registra	r's Signat	d. A	gation, in my opinio eath occurred at the 29c. License						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First Middle | ast) 2. Date of Death Physician/ 10:30A M BEATRICE LILLIAN COMMERFORD 20° Medical 4a. Facility Name (if not institution, give street and number) Sounty of Death or Location of Death Examiner HARLES MEDICAL VISTA If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign ial Security Number 8. Date of Birth **Funeral** Month Pay, Year) 16 1 M 2 X F 113-14-1597 95 Yrs. CANADA Director Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10a State 10b County 10c. City, Town or Location Examiner must be notified at death with the Maryland Director LA PLATA MD. CHARLES 1 Yes 2 XNo 10e. Street and Numbe 10g. Citizen of What Country? 9 10f. Zip Code Funeral items 23a U.S.A. 9335 WINKLER LANE 20646 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc o þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. filed within 72 hours after 1 ☐ Yes 2 🔀 No Specify Specify: WHITE "natural", 3 ₩ Widowed 4 Divorced Completed injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) FERROXCUBE CORP. permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event. The Me Elementary/Seconday (0-12) College (1-4 or 5+) OF AMERICA TECHNICIAN Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည JULIA BURNING ENOCH HOMES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LA PLATA, MD. 20646 BEATRICE RICKS-DAUGHTER 9335 WINKLER LANE 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 XCremation 3 Removal from State METROPOLITAN ALEX., VA. CREMATORY 725-11 4 ☐ Donation 5 ☐ Other (Specify) of Ineral Service Licenses M20479 Name and Address of Facility RAL SERVI YLAND 206 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate tval Between Immediate Cause (Final Physician/ 13chenia disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed and -trans Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 E FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 pronths?

1 yes 2 No 9 Unknown 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Day Year Pregnant at time of death ☐ Pregnam. ☐ Unknown signed by t Other significant conditions contributing to geath but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown cate has been sig page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? autopsy eral Director: After this certificate I filled in by the funeral director, page 2 🗌 No 2 A N 1 🗌 Yes Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 Nnpatient 2 ER/Outpatient 3 DOA 27. Manger of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Matural 5 Pending 1 Tes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral D Medical celtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Expression: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Medical ath occurred at the time, date and place, and due to the cause(s) and manner as stated. only one r: To the best of my knewledge, de 29b. Signature

Jou

State Registrar 31. Date filed (Month, Day, Year

of death (Item 23a) (Type, Print)

		1	For State Registrar	State of Ma	aryland /	•	artment of H tificate of D			iene eg. No. 201	1 24239
Р	hysicia Medic		1. Decedent's Name (First, Middle, L LORRAINE	ast) CARTER	C	CARTE	IR		2. Date of Deat Month JULY 12	h Day Yea 2,2011	3. Time of Death 2:01P M
and the same of th	Examin		4a. Facility Name (if not institution, g FREDERICK MEMO		ral.		4b. City, Town, or FREDER			4c. County of D	
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nd 21215-0036 filed within 72 hours after death with the Maryland al Hygiene.	ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ed by Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 Yes, Give Year or Dates.		If	Vas Decedent of His Yes, specify Cubar ☐ Yes 2 💆 No	n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	Black, W	merican Indian, /hite, etc. White
Maryland 21215-0036 2 should be filed within 72 hours after th and Mental Hygiene.	er than "natu the Medical	Completed	15. Decedent's (Specify only highest Elementary/Seconday (0-12) 12	Education grade completed) College (1-4 or 5		(Give k	ent's Usual Occupa ind of work done do NOT use retired) ounts Pay	uring most of work	ing	16b. Kind of Busine	ess Industry Government
yland Id be filed v Mental Hyg	irked other	To Be	17. Father's Name (First, Middle, Las Jay Daniel Ca	arter	•			18. Mother's Nam	e (First, Middle, N	laiden Surname)	eman
	7 is m traum		19a. Informant's Name/Relationship James Gordon Ca							City or Town, State,	.Zip Code) .and 21771
	int: If item 2 iry or other		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spe		cemet	tery, crem	sition (Name of natory or other place)		20c. Location - City	or Town, State
Balti permit. Departn	Important: I: any injury oi once.		21. Signature of unerselection		1004	22	Name and Addres Muriel H	s of Eacility Barber	Funeral		
	sician/	1 1 1/4	23a. Pary 1. Enter the disease, or construct, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each line			r the mode of dying	, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
	edical miner	ner	resulting in death) Securities is any leading to immediate	Due/ (or as a	consequence	e of): اسر حرجه e of):	hal pa-	ermonit	1/ (VI	PIZAE)	years
executed	ian and ırial-transit	al Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or as a	consequence	e of):					
/60 icate be	physic s the bu	ledical		d							
DIVISION OF VITAI RECORDS, P.O. BOX 68 / 60 no the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	/ the attending ched for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12.months? 1 ☐ Yes 2♣No 9 ☐ Unknown	23c. If yes, outcome of Live Birth 4 Pregnant at 9 Unknown	2 🗌 Fetal dea		Ectopic pregnancy Other (specify)	/		23d. Date of Month	delivery Day Year
S, P.O.	n signed by Ild be deta	þ	Part II. Other significant conditions	contributing to death be	ut not resulting	j in the ur	nderlying cause give	en in Part I.	23e. Did tob		e to the cause of death? Probably 4 Unknown
VITAI KECOrdS, sysician: The law requires	ate has bee page 2 shou	Completed							24a. Was ar autops perform	y prior ned? deatl	autopsy findings available to completion of cause of n? Yes 2 \sum No
/Ital	certific irector,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐No	Hospital:			Otho	ce of Death (Chec	k only one)	•	
oding Phy	: After this funeral d	cate: To	27. Manner of Death 1 Paral Service Pending 2 Accident Investigat	28a. Date of injur (Month, Day		Time of injury	28c. Injury works	at	ome 5 □ Reside 28d. Describe ho	nce 6 Other (S) w injury occurred	pecify)
DIVISION OT al or Attending Pr 's after death.	I Director	Certificate:	3 Suicide 6 Could no 4 Homicide determine	be 280 Place of Inju	ry - At home, i . (Specify)	farm, stre	et, factory, office		28f. Location (Str City or Town		Rural Route Number,
he Hospit in 24 hour	he Funera pleted fille	Medical	(Check 2 L Medical Exa	hysician: To the best of miner: On the basis of exurse Practioner: To the l	kamination and	or investi	igation, in my opinio	n, death occurred a	t the time, date and	d place, and due to t	he cause(s) and manner stated.
lo t with	To t		29b. Signature and title of certifier	1,000			29c. License	number マクル し	25	Od. Date signed (Mo	onth, Day, Year)
to				o completed cause of de	eath (Item 23a) イベン い	(Type, P	rint) /+ y Fr	edenty 1	18 2170		
R	Stat legistra		31. Date filed (Month, Day, Year)	2011 32. Registra	r's Signature	4	Ay Fr				

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend items 10a-c,e,f,19b per inf g919 9-21-11 vt
State of Maryland / Department of Health and Mental Hygiene = For State Registrar 24240 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 20^{Year} Physician/ 10:38AM Noble L. Darrow Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Worcester Ocean City 10100 Coastal Hwy If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 1/30/1946 Days Hours Min 1**X** M 2 □ F 055-36-6749 65 Director Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or item. 10b County **VA. Beach City** 10d. Inside City Limits 10a. State 10c. City, Town or Location Funeral Director 1 X Yes 2 ☐ No Richmond Virginia Beach 3288 Page Ave. Unit #1608 10f. Zip Code 10g. Citizen of What Country? 23451 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Bace - American Indian. Black, White, etc. 1 Never Married 2X Married Completed by Yes 2 🔯 No If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: 3 Divorced 4 Divorced white 15. Decedent's Education Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Acurate Marine life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Environmental Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mary McConologue Noble Darrow 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ryral Boute Number, City or Town, State, Zip Code)
3288 Page Ave Unit #1608 Virginia Beach VA, 23451 Ann T. Darrow / wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 XCremation 3 Removal from State Rose Hill Crematory 7/16/11 4 Donation 5 Other (Specify) Linden, NJ f Funeral Service Licensee 22. Name and Address of Facility Burbage Funeral 108 William St., Berlin, 21811 MD23a. Part 1/ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 43CU () Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Month Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕶 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No After this certificate has page 2 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospital: 2 🗆 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA Hotel 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 Yes 2 No 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident Investigation within 24 hours after death To the Funeral Director: completed filled in by the 6 Could not be Suicide 26e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical tying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated deritiving Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only or 29b. Signat 29c. License number 29d. Date signed (Month, Day, Year) 7/13(11 ompleted cause of death (Item 23a) (Type, Print) 30. Name Snjisky ND 21801 BA 30 100 ECamo

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day,

1 5 2011

Registrar's Signature

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	-	For State Registrar	St	ate of N	/larylan		artment of	Health and <i>Death</i>	Mental Hy	giene Reg. No. 2	011	21, 21, 1
Dhygioia	n/	Decedent's Name (First, Middle)	, Last)						2. Date of De	eath	O Quen	3. Time of Death
Physicia Medic	al	JOYCE ELIZABET 4a. Facility Name (if not institution,					4b. City Town	or Location of Dea	JULY	1 ⁰ 5 ^y	2011 unty of Death	7:49 A M
Examin	er	FORT WASHINGTO						ASHINGTO			CE GEOR	GES
Funeral Director		5. Social Security Number 217–76–7633	6. Sex 1 ☐ M :	7. A		ast birthday) Yrs.	If Under 1 Year Months Days			th 15°ar) 19	9. Birthp	lace (State or Foreign
		Usual Residence of Decedent 10a. State 10b. County				y, Town or Lo	cation					d. Inside City Limits
Aarylan Ba-f sh tified a	Director	MD CHARL	ES			APLATA						1 X Yes 2 No
th the N 3a or 2 t be no	al Di	10e. Street and Number		n			10f. Zip Code 206	1.6			of What Count	
eath wi	Funeral	657 PISCATAWAY 11. Marital Status	12. W	as Decedent		S. 13. V	Nas Decedent of	Hispanic Origin? (5	Specify Yes or No-		Race - America	
after d	þ	1 X Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced	ried 1	rmed Forces Yes 2 [Yes, Give			r ves, specify Cub I ☐ Yes 2 🕱 N	oan, Mexican, Puer o <i>Specify:</i>	no Rican, etc.)		Black, White, e	
2 hours "natura dical E	Completed	15. Deceder (Specify only higher	nt's Education			16a. Deced	dent's Usual Occu	pation during most of we	orkina	16b. Kind	of Business Ind	ustry
rithin 73	Com	Elementary/Seconday (0-12)		ollege (1-4 or	r 5+)	life. D	O NOT use retired			HEALT	TH CARE	
tal Hyg tal Hyg td othe event,	To Be	17. Father's Name (First, Middle, L	ast)					1	ame (First, Middle		,	
ould be ould be marke matic		SIDNEY DUCKETT 19a. Informant's Name/Relationsh	nip (Tvpe, Pri	int)		10h Mailir	on Address (Stree	ESSIE and Number or R	MAE LYLE			nde)
nd 2 sh ealth ar m 27 is ner trau		SYLVIA JIGGETTS						GREEN DR				
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If time Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 XBurial 2 Cremation 4 Donation 5 Other (S	3 🗆 Remo	val from Stat	0	cemetery, cren	sition (Name of natory or other pla	rdens jul	Date V 23 20		ion - City or To	wn, State MARYLAND
ermit. P epartme portar y injur		21 Signature of Funeral Service L	isonsee /	Q9		Ť	HORNTON	UNERAL HOM	E, P.A.			
20 E # 9		23a. Part 1. Enter the disease, or				3	439 LIVI	NGSTON R	COAD, INI		EAD, MD	20640 Approximate
hysician/		shock, or heart failure. List of Immediate Cause (Final disease or condition	nly one cau	se on each li	ne.		tic Co		artery	1	ease	Interval Between Onset and Death
Medical Examiner		resulting in death)	r a	Due to (or a								
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. —	Due to (or a	s a consequ	uence of):						
be executed sician and burial-transit	Examiner	Cause (Disease or linjury that initiated events resulting in death) Last	c	Due to (or a	s a consequ	uence of):						
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death certificate te attending physed for use as the		IF FEMALE:	23c. lf	yes, outcom	e of pregna	ancv				00-	Data of deliver	
e atten	siciar	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 4	Live Birth Pregnant Unknown	n 2 ☐ Feta at time of o	al death 3	Ectopic pregnar Other (specify)	ncy		230	. Date of delive Month	ry Day Year
		9 ☐ Unknown Part II. Other significant condition				sulting in the u	inderlying cause g	iven in Part I.	23e. Did 1	tobacco use o	contribute to the	e cause of death?
requires that the	Completed by	Hyperte Diabeles	nsiov	1					. 1 🗆	Yes 2 🔽	No 3 🗆 Prob	abiy 4 🗆 Unknown
law rec has bee e 2 sho	nplet	Diabeles	M	ellita	15	٠١. سي			24a. Was	psy	4b. Were autop prior to cor death?	sy findings available npletion of cause of
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his cert	To Be	examiner? 1 Yes 2 No	Hospit	1 L Inpa	atient 2 🗹		nt 3 🗆 DOA Ot	her: 4 Nursing	Home 5 Resi	dence 6 \Box	Other (Specify)	
th.: After te funera	cate:	27. Manyer of Death 1 M Natural 5 ☐ Pendir 2 ☐ Accident Investig	g	Ba. Date of in (Month, D	ijury Jay, Year)	28b. Time of injury	wo		28d. Describe	how injury oc	curred	
or Atter fter deg irector n by the	Certificate:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	not be		njury - At ho etc. (Specify		eet, factory, office	_	28f. Location (City or To		ımber or Rural	Route Number,
o the hospital or Attending Prhysician: The law within 24 hours after death. To the Funeral Director, After this certificate has sompleted filled in by the funeral director, page 2 sompleted filled in by the funeral director, page 2 sompleted filled in the funeral director.								e, date and place,				
the Ho	Medical	only one) 3 Certifying	xaminer: Or Nurse Prac	n the basis of	examination ne best of m	y knowledge, o	death occurred at t	he time, date and p	d at the time, date blace, and due to the	ne cause(s) an	d manner as sta	
8 5 ½ 5		29b. Signature and title of certific			MD		29c. Licen	6741		7 V V	gned (Month, E	
CB		30. Name and address of person	1		death (Item					(
Stat	e :	Deepak Sacho	deva.	M D				ROAD, F	ORT WASH	INGTON	, MD 20	0744-5164
Registra	ır	JUL 18	2011	agree	un",	ture &	and the state of					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney For State Registrar 24242 Certificate of Death Rea No 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Year 2011 Physician/ amola 10: 20 A M ulu Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washinston Med Center H more Anne Arundel If Under 24 Hrs. 9. Birthplace (State or Foreign 7 Age (In vrs. last hirthday) If Unde 8 Date of Birth **Funeral** 1 □ M 2 💢 F Min Hours ENGLAND 216-80-463 Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 72 hours after death with the Maryland 10d. Inside City Limits Director **MILLERSVILLE** MD ANNE ARUNDEL 1 ☐ Yes 2X No 10e. Street and Numbe 10f. Zip Code ö 10g. Citizen of What Country? "natural", or items 23a or Funeral 8187 WEYBURN ROAD 21108 UNITED STATES 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Was Deceud... Armed Forces? Ves 2X No 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 X Married by Maryland 21215-0036 If Yes, Give Year or Dates 1 Tes 2 X No Specify: Specify: WHITE 3 Widowed 4 Divorced Completed Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working I Hygiene. life. DO NOT use retired) within 7 Elementary/Seconday (0-12) College (1-4 or 5+) the 12 4 HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishers is marked of ပ FREDERICK JANAWAY ELIZABETH DOUGLAS traumatic Page 1 and 2 should I 19a. Informant's Name/Relationship (Type, Print) GRAND-19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. GINA FOLDERAUER / DAUGHTER 741 MATCH POINT DRIVE, ARNOLD, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State CHESAPEAKE CREMATION 07/14/2011 4 ☐ Donation 5 ☐ Other (Specify) STEVENSVILLE, MD 22. Name and Address of Facility LASTING TRIBUTES BY FELLOWS HELFENBEIN & NEWNAM CREMATION & FUNERAL CAIP.A. 814 BESTGATE ROAD, ANNAPOLIS, MD 2140 Signature of Juneral Service Lig a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ oneumonia disease or condition Medical resulting in death) **Examiner** non-small cell cancer Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-trar Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Day Month Year Pregnant at time of death signed by the a Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? 1 Yes 2 No certificate 2 No 1 Tes 25. Was case referred to medica within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, B 26. Place of Death (Check only one) examiner? 2 X No Other: 1 🗌 Yes မ 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 2 🗌 No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier

500

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

ELIZABETH MCILMOYLE, MD

DODG 9434

100 SOUTH PACA ST. #2ND, BALTIMORE, MD

10

21201

State of Maryland / Department of Health and Mental Hygiene,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

21 21 2

Physicia Medi Exami

Funeral

Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician/ Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760

State Registrar

	1 - State Registrar	Certificate of Death	Reg. N	ZUII	24243
in/	1. Decedent's Name (First, Middle, Last) Austin L. Detweiler		2. Date of Death Month July	2011 11 2011	3. Time of Death 10:00 A M
er	4a. Facility Name (if not institution, give street and number) Arbor at Baywoods	4b. City, Town, or Location of Annapo	lis	Anne A	rundel
	5. Social Security Number 6. Sex MX M 2 \square F 7. Age (In yrs. last 91)	t birthday) If Under 1 Year If Under 2 Yers. Months Days Hours	24 Hrs. 8. Date of Birth Min. (Month, Day, Year NOV. 28	9. Birth	place (State or Foreign htry) Inois
Funeral Director		Town or Location Annapolis			10d. Inside City Limits 1XXYes 2 □ No
eral D	7101 Bay Front Drive, #407	10f. Zip Code 2140	3 10g. G	Citizen of What Cou U.S.A.	ntry?
ted by Fur	11. Marital Status 1 □ Never Married 2 ▼ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ▼ Yes 2 □ No If Yes, Give Year or Dates. ₩₩ ፲፲	13. Was Decedent of Hispanic Orig If Yes, specify Cuban, Mexican, 1 Yes 2 X No Specify:	jin? (Specify Yes or No- , Puerto Rican, etc.)	14. Race - Americ Black, White, Specify: Whi	etc.
Completed by	(Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most life. DO NOT use retired) Operations Anal	of working	Kind of Business In	
To Be C	17. Father's Name (First, Middle, Last) Milan Detweiler		er's Name (First, Middle, Maide Ce Ann Mitche		ado er y
	19a. Informant's Name/Relationship (Type, Print) Lanelle Detweiler/wife	19b. Mailing Address (Street and Number 7101 Bay Front Dri			
	1 Burial 2 X Cremation 3 Removal from State	ce of Disposition (Name of netery, crematory or other place) timore Crematory		Location - City or To	
	21. Signature of Fungal Service Vicensee	22. Name and Address of Facility 147 Duke of Glo			
			cardiac or respiratory arrest,		Approximate Interval Between Onset and Death months
ı.	resulting in death) Due to (or as a consequent b.	nce of):			
xamine	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events c.				
/Medical Examiner	resulting in death) Last Due to (or as a consequence of the consequen	nce ot):			
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnant 1 □ Live Birth 2 □ Fetal december 1 □ Pregnant at time of december 2 □ Vision 1 □ Vision 1 □ Vision 2 □ Vis	death 3 🖳 Ectopic pregnancy		23d. Date of deliv Month	very Day Year
d by Pr	Part II. Other significant conditions contributing to death but not result	ting in the underlying cause given in Part I		o use contribute to t	the cause of death?
Completed by Physician			24a. Was an autopsy performed?	24b. Were auto	opsy findings available ompletion of cause of
To Be (25. Was case referred to medical examiner?		th (Check only one)	Assist	ed Living
2			ursing Home 5 Residence		yFacility_
ficate	27. Manner of Death 12. Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	8b. Time of injury at work? M 1 Yes 2	28d. Describe how inj	ury occurred	
Medical Certificate:	4 Homicide determined 28e. Place of Injury - At nom building, etc. (Specify)		28f. Location (Street a City or Town, Sta	te)	
Medic	29a. Certifier (Check only one) 3 Certifying Physician: To the best of my knowled only one) 3 Certifying Nurse Practioner: To the best of my knowled to the best of my knowled	and/or investigation, in my opinion, death oc knowledge, death occurred at the time, date	curred at the time, date and pla and place, and due to the caus	ce, and due to the ca e(s) and manner as s	ause(s) and manner stated. tated.
	29b. Signature and title of contifier	29c. License number D21438	29d. [July 13,	
	30. Name and address of person who completed cause of death (Item 2 Michael J. LaPenta, MD 445 Defe		olis, Maryland	d 21401	

31. Date filed (Month, Day, Year) **JUL 14 2011**

park

			Please State Registrar 20b, 20c, 7/	Type or Pri	nt in	Black I	ndelik er fi	ele ink	Ensur	re All Cop	es Ar	e Legible.	
Λ.	ended20		For State Registrar 20b, 20c, 7/	Amend 25 12/11, M.	per S. Ke	med rent Co	ec G	918 8 te of L	725/11 Death	dk	Reg. N	2011	24244
All	Physicia		1. Decedent's Name (First, Middle, La	st)		niels				2. Date of Month	Death	Year 2011	3. Time of Death
-	Medic Examin		4a. Facility Name (if not institution, give		<u> </u>		$\overline{}$		Location of I		4	c. County of Deat	h
-	Funeval		5. Social Security Number 6. 5	spital Sex 7.Aa	ie (In vrs. la	ast birthday)	If Unde	Eas-	ten If Under 24	Hrs. 8. Date of	Birth	Talbo g. Bin	thplace (State or Foreign
	Funeral Director		212-40-9947	X M 2 □ F	69	Yrs.	Months	Days	Hours	Min. (Month, 6—15-	Day, Year)	MARY	LAND
	show dat	tor	Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	ocation						10d. Inside City Limits
	death with the Maryland r items 23a or 28a-f sho ner must be notified at	Director	MD QUEEN A	NNE'S	MIL	LINGTO		p Code			100.0	Citizen of What Co	1 Yes 2X No
	with the s 23a oust be	Funeral	211 SPRING RD.					21651			109. (USA	
N	r items	/ Fun	11. Marital Status	12. Was Decedent Armed Forces?		S. 13.	Was Dece If Yes, spe	dent of Hi	spanic Origin n, Mexican, F	? (Specify Yes or I Puerto Rican, etc.)	Vo-	14. Race - Ame Black, White	
Daniel 215-0036	within 72 hours after giene. er than "natural", o , the Medical Exami	ed by	1 ☐ Never Married 2 🙀 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔀 If Yes, Give Year or Dates.	No		1 🗌 Yes	2 🕱 No	Specify:			Specify: B	LACK
0α 15-6	72 hou n "nati Aedica	Completed	15. Decedent's l (Specify only highest g	rade completed)		(Give	edent's Usi kind of wo	ork done d	ation luring most o	f working	16b.	Kind of Business	Industry
3.2	within /giene. ner tha t, the h		Elementary/Seconday (0-12)	College (1-4 or	5+)	LINEM				<u>.</u>	Ā	VIATION	
्र or and	be filed ental H ked otl	To Be	17. Father's Name (First, Middle, Last) JAMES ALFRED DAN	TFTC						s Name <i>(First, Mid</i> LINE ELIZ			т
(Saryl	should and Me is marl aumati		19a. Informant's Name/Relationship (19b. Mail	ing Addres	ss (Street a		or Rural Route Nur			
رير e, ⊼	and 2 s Health em 27 ther tra		JOAN DANIELS/WIF	E	20b E	211 Place of Disp			D. MII	LINGTON,		21651 Location - City or	Town State
Samuel timore, M	Page 1 ment of I ant: If it		Burial 2 K Cremation 3 L	Removal from State	Ché	ซสซอลา	retor Cr	emate.	fon ERY 7-	7-15-201 - 15-201	i St	evensvil LLINGTON	le, MD.
Samuel Geor	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signal re of Funeral Service Licer		,) 2	2. Name a	nd Addres	ss of Facility	BEIN & NE	WNAM	FUNERAL	HOME P.A.
	202 00		23a. Pat 1. Enter the disease, or con				YO M	<u> CYP</u>	KESS S	T. MILLI	NGTO	N, MD 21	Approximate
- 1	Physician/	1	shack, or heart failure. List only Immediate Cause (Final disease or condition	M40	CAN	DIAL	. In	IFAR	ection 2	N			Interval Between Onset and Death
- Same	Medical Examiner		resulting in death)	Due to (or as	a consequ	uence of): CULA	R T	ACH	HYCA	ROIA			
3	7 =	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a consequ	uence of):	. DA	=111	, 01	SEASE	-		
9	executed ian and irial-transit	Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	Due to (or as	a consequ	uence of):							
2 00	ate be e hysician the buri	Physician/Medical		d. AT	HER	osci	ERO	TIC	CAR	DIOVAS	CULA	LR OISE	ASE
6876	eath certificate be attending physici for use as the bu	ın/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregna	ancy	7 Catania				-	23d. Date of de	livery
Box	e death the atte	ysicia	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant a 9 Unknown			Other (s		- -		_	Month	Day Year
P.O.	requires that the de been signed by the should be detached	by Ph	Part II. Other significant conditions	contributing to death t	out not res	sulting in the	underlying	cause giv	en in Part I.			/	the cause of death?
rds,	equires sen sign	ted k											Probably 4 Unknown
ecol	e law re has be ge 2 sh	Completed								l p	utopsy erformed?	prior to death?	utopsy findings available completion of cause of
a B	sician: The law r s certificate has b lirector, page 2 s	Be Co	25. Was case referred to medical					26. Pla	ace of Death	(Check only one)	es 2 🗜	No 1 ∐ Ye	s 2 MNo
Vit	Physici this ce al direc	으	examiner? 1 Yes 2 No 27. Manner of Death			ER/Outpatie			4 L Nurs	sing Home 5 🗆 F			cify)
o uo	nding Fath. :: After e funer	icate	1 Natural 5 Pending 2 Accident Investigation	28a. Date of inju (Month, Da	y, Year)	28b. Time o injury	M	28c. Injury work 1 🗌	yat ? Yes 2 □ N		oe how inj	ury occurred	
Division of Vital Records, P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director After this certificate has been signed by the attending physic completed filled in by the funeral director, page 2 should be detached for use as the b.	Certificate:	3 Suicide 6 Could not 4 Homicide determined	be 280 Place of Ini	ury - At ho c. (Specif)	ome, farm, st	reet, facto	ry, office		28f. Locatio City or	n (Street a Town, Sta	and Number or Ru te)	ıral Route Number,
	To the Hospital within 24 hours a To the Funeral C completed filled	Medical	(Check 2 Medical Exan	sician: To the best of niner: On the basis of e	examination	n and/or inve	stigation, in	n my opinic	on, death occu	urred at the time, da	ate and pla	ce, and due to the	cause(s) and manner stated.
	To the within 2 To the Comple	Ĭ	29b. Signature and title of certifier	rse Practioner: To the	best of m	y knowledge,		urred at the		nd place, and due		e(s) and manner as Date signed (Mont	
	12		> folia	metri				po	0594	87		7-6-20	011
	Tm		John Botsis	completed cause of c	leath (Item	1 23a) (Type,	Print)	nn S	St. E	aston.	Mi) 216	01
	Stat Registra	e ar_	31. Date filed (Month, Day Year)	2011 32. Registr	ar's Signa	ture	bas	20		· · · · · · · · · · · · · · · · · · ·			

			Ple	ase Type or AMEND State o	Print in TTEM#2 of Maryla	Black II 3a, pt I nd / Dep	ndelible IperPH artment	Ink. En YS G918 of Health	sure 6	VII Copie 72011, W Mental Hy	s Ard	e Leg i e	ible.	
			1 - State Registrar				rtificate (Reg. N	α		24245
	Physicia Media		1. Decedent's Name (First, Middle Avhur I	1	MS					2. Date of Do Month		ay 25	Year	3. Time of Death
	Examir	ner	4a. Facility Name (if not institution	ka Park			Seve	vn, or Location	Parl	4		C. County	ne	Arwall_
	Funeral Director		5. Social Security Number 162-20-7217 Usual Residence of Decedent	6. Sex 1 🔀 M 2 ☐ F	7. Age (In yrs. 86	last birthday) Yrs.	If Under 1 Months D	Year If Under Days Hours	Min.	8. Date of Bi (Month, D Mar. 1	rth ay, Year) 6,1 9	925	Cour	olace (State or Foreign otry) Sylvania
	/land f show ed at	tor	10a. State 10b. County			ity, Town or Lo							1	0d. Inside City Limits
	he Mar or 28a- s notifie	Director	MD Anne 10e. Street and Number	Arundel		Severna	10f. Zip Co	ode			10a. C	itizen of W	/hat Cour	1 Yes 2 XNo
	s 23a oust be	Funeral	156 Berrywood	d Drive				21146				JSA		,
980	s filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed by Fur	11. Marital Status 1 ☐ Never Married 2 🌠 Mar 3 ☐ Widowed 4 ☐ Divorced	Armed Fo	edent Ever in Universes? 2 Nover 1943–19	964	Was Decedent If Yes, specify 1 ☐ Yes 2 ∑			ecify Yes or No Rican, etc.)	-		- Americ k, White, Wh	
21215-0036	72 hou n "natu /edical	nplet	(Specify only high	nt's Education est grade completed		(Give	dent's Usual O kind of work do O NOT use ret	one during mo	st of work	ing	16b. I	Kind of Bu	siness In	dustry
	ed within Hygiene. other tha		Elementary/Seconday (0-12)	College (1	-4 or 5+)		ficer				τ	J.S.	Navy	
Maryland	ould be filed Id Mental Hy marked ott matic even	To Be	17. Father's Name (First, Middle, Robert Divens	Last)				_ I		e (First, Middle Mannerk		Surname)		
	2 shouth and it is muttraum		19a. Informant's Name/Relations Catherine Medi		s/Wife					il Route Numb S evern a				
Baltimore,	nit. Page 1 and 3 nartment of Healt ortant: If item 2 injury or other		20a. Method of Disposition 1 XBurial 2 Cremation 4 Donation 5 Other (3 ☐ Removal from Specify)	State	cemetery, crer	sition (Name on matory or other	r place)	8/30 neter			ocation - i	•	
Balt	permit. Page Department of Important: If any injury or once,		21. Signature of Funeral Service I	icensee		22 B	Name and A	ddress of Faci	is, P	.A. Sev	erna	a Par	k Fu	neral Home
			23a. Par ut. Enter the diseal e, or shoot, or head it iffure. List o	complications that conly one cause on ea	aused the dea		95 Riter the mode of					Par	K, M	D 21146 Approximate Interval Between
_	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to	or as conseq	the 1	eart	Fail	me				_	Onset and Death
	Examiner	Į.	Sequentially list conditions,	b	brond	my 1	frien	y (2)	Has	e			0/	Manour
	executed an and rial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	c. A	tin	- F	brill	gillor	1				a	enlenous
09			resulting in death) Last	d	or as a conseq and w		P TH	inhe	_				_	lyear
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be exwining 12 the Carbon branch and a state death. To the Tuneral Director After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burian	Completed by Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Birth 2 Feta	aldeath 3 🗔	Ectopic preg Other (specif					23d. Date Mon		ery Day Year
ls, P.O.	v requires that the de been signed by the should be detached	d by P	Part II. Other significant condition	ons contributing to d	eath but not res	sulting in the u	nderlying caus	se given in Par	t I.					e cause of death?
ecorc	e law requ e has beer ge 2 shou	mplet	Periphe	ac V	ascul	ar C	Lisca	De		24a. Was auto		pr	ere autorior to co	osy findings available inpletion of cause of
a B	Physician: The law a rubis certificate has beral director, page 2 s	Be Co	Mesothelion 25. Was case referred to medical	a			2	6. Place of De	ath (Check	1 🗆 Yes	2 🜠 N	lo 1	☐ Yes	2 No
Z;	hysici his cer I direc	욘	examiner? 1 Yes 2 No	Hospital:	Inpatient 2	ER/Outpatien	t 3 🗆 DOA	Other: 4 N N	lursing Ho	me 5 🗆 Resi	dence 6	6 🗌 Other	(Specify	1
on of	ttending Pl death. ctor: After tl y the funera	Certificate:	27. Manner of Death 1	gation	of injury h, Day, Year)	28b. Time of injury		Injury at work? 1 □ Yes 2 □	_	28d. Describe	how injur	ry occurred	q	
Division of Vital Records,	To the Hospital or Attend within 24 hours after death To the Funeral Director: completed filled in by the		3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ined 28e. Place	of Injury - At hong, etc. (Specif)	ome, farm, stre	eet, factory, off	ice		28f. Location (City or Tou			or Rural	Route Number,
	ne Hosp n 24 hou ne Funer pleted fil	Medical	(Check 2 L Medical E	Physician: To the be xaminer: On the bas Nurse Practioner:	is of examination	n and/or invest	igation, in my c	pinion, death of	occurred at	the time, date a	and place	e, and due t	to the cal	ise(s) and manner stated.
	vithi To th		29b. Signature and title of certifier	, cri	p.		29c. Lic	ense number	7		29d. Da	ate signed	(Month, I	Day, Year)
i	f5+1		30. Name and address of person		e of death (Item	23a) (Type, P			de	mi	16	40/		<u> </u>
	Stat Registra	e ir	31. Date filed (Month, Day, Year)	2011 32. Re	gistrar's Signa	b. A	harke							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 24246 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Montb 07/13 2011 Year Physician/ Isabelle Ann Forrest 8:13 a M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Calvert 900 Cameleer Pass Owings 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Yea an. 2, 1 1 ☐ M 2**X X**F Months Min. 89 Director Yrs MA 022-14-9778 Usual Residence of Decedent 23a or 28a-f shov 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director 1 Yes 2XXNo Calvert Owings MD 10e. Street and Numbe 10f. Zip Code 10q. Citizen of What Country? 20736 U.S.A. 900 Cameleer Pass Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Bace - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married If Yes, Give 1 ☐ Yes 2 🗙 No Specify: Specify: White 3xxWidowed 4 ☐ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) House wife Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be fi h and Mental 7 is marked Anna Nunnes Joseph Roderick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a: Important: If item 27 is any injury or other tra 8250 Harrison Blvd., Chesapeake Beach, MD 20732 Judy Cumbo/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07/16/2011 Lee Crematory Clinton, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. Amanda Ergler 8200 Jennifer Lane, Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Refractory Immediate Cause (Final disease or condition Physician/ Progressive Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be a hin 24 hours after death. IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death been signed by the sahould be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? sufficience 24a. Was an autopsy performed? Yes 2 L MOIDS ancek 1 Yes 2 No To Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the 1 only one) death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar Kaymon

drw)

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

328 Merriman Ct. Prince Fred, M.

			101	epartment of Health and Mer Certificate of Death	ntal Hygiene Reg. N2 0 1 1	24247
	Physicia Medic		1. Decedent's Name (First, Middle, Last) John Frazer, Jr.		Date of Death Month Day Year 201	3. Time of Death 1 8:20 A M
	Examin		4a. Facility Name (if not institution, give street and number) 220 Claude Street	4b. City, Town, or Location of Death Annapolis	4c. County of Dea Anne	Arundel
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho 88 Yr Usual Residence of Decedent	day) If Under 1 Year If Under 24 Hrs. 8. Months Days Hours Min. OC	Date of Birth (Month, Day, Year) Co	thplace (State or Foreign suntry) France
	aryland ia-f show ified at	ector	10a. State 10b. County 10c. City, Town of Maryland Anne Arundel	Annapolis		10d. Inside City Limits 1XXYes 2 ☐ No
	with the M 23a or 28 ist be not	Funeral Director	10e. Street and Number 220 Claude Street	10f. Zip Code 21401	10g. Citizen of What C	ountry?
9036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 XX Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 14. Was Decedent Ever in U.S. Armed Forces? 15. Yes 2 No If Yes, Give 1943–46	13. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica 1 ☐ Yes 2 ☑ No Specify:		
Baltimore, Maryland 21215-0036	ithin 72 hou ene. • than "natu the Medica	Completed	(Specify only highest grade completed) ((Decedent's Usual Occupation Give kind of work done during most of working fe. DO NOT use retired Genealogist	16b. Kind of Business Self Emp	
land 2	l be filed w fental Hygi rked other tic event, t	To Be	17. Father's Name (First, Middle, Last) John Frazer, Sr.	18. Mother's Name (Fin Mary Fox	rst, Middle, Maiden Surname) kley Tighman	
, Mary	nd 2 should saith and M n 27 is ma er traumai		19a. Informant's Name/Relationship (Type, Print) Walter Arps/friend 19b. 1 22	Mailing Address (Street and Number or Rural Ro O Claude Street Annag	ute Number, City or Town, State, Zi colis, Maryland	ip Code) 21401
imore	Page 1 an ment of He ant: If iten ury or oth		1 Purisi AFT Cramation 2 Paraual from State Cemetery.	Disposition (Name of crematory or other place) Ore Crematory 7/13/20)11 Baltimore,	Maryland
Balt	permit. Departi Import any inji		21. Signature Founeral Service Censee	22. Name and Address of Facility John 147 Duke of Glouceste		
J.	Physician/		23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Type II Diabe	tes	spiratory arrest,	Approximate Interval Between Onset and Death 5 Years
	Medical Examiner		resulting in death) Due to (or as a consequence of) Advanced Age Sequentially list conditions,	:		8 years
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underl, in Cause (Disease or iinjury that initiated events c.			
09	cate be executed physician and s the burial-transit	dical Ex	resulting in death) Last Due to (or as a consequence of) d.			
687	or Attending Physician: The law requires that the death certificate be executed that death. Differ death. Differd death. Differd death. Differd this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of de Month	elivery Day Year
, P.O.	es that the	by	Part II. Other significant conditions contributing to death but not resulting in Atrial Fibrillation	the underlying cause given in Part I.	23e. Did tobacco use contribute to	
Division of Vital Records, P.O. Box	law requires th	Completed	High Cholesterol		24a. Was an autopsy 24b. Were at prior to	utopsy findings available completion of cause of
al Re	sician: The law certificate has rector, page 2 s	Be Cor	25. Was case referred to medical examiner?	26. Place of Death (Check onl		s 2 No
of Vit	g Physic er this ce reral dire	욘	1 ☐ Yes 2 ★ 1 ☐ Inpatient 2 ☐ ER/Outs 27. Manner of Death	ne of 28c. Injury at 28d.	5 X Residence 6 Other (Spe-	cify)
Sion	Attending Firdeath. ctor: After by the funer	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	M 1 ☐ Yes 2 ☐ No	Location (Street and Number or Ru	ural Route Number,
Ω	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completed filled in by the fu		building, etc. (Specify) 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, de	eath occured at the time, date and place, and du	City or Town, State) ue to the cause(s) and manner as si	ated.
	o the Ho rithin 24 h o the Fur	Medical	(Check 2 Medical Examiner: On the basis of examination and/or in only one) 3 Certifying Nurse Practioner: To the best of my knowled 29b. Signature and tiple of certifier			s stated.
_			1 fluctions !	00054903	7/12/1	11
	对对			olomons Island Road A	Annapolis, Maryl	and 21401
	Stat Registra		31. Date filed (Month, Day, Year) JUL 13 2011 32. Registrar's Signature	park		

DHMH 17 Rev 7/2009

			For State of Ma State Registrar	ıryland	-	rtment of <i>ificate of</i>				giene Reg. Na	011	24248
	Physicia	n/	1. Decedent's Name (First, Middle, Last)						2. Date of Dea		Year	3. Time of Death
-	Medic Examin	al	Margaret Lucille Fisher 4a. Facility Name (if not institution, give street and number)			4b. City, Town,	or Locatio	on of Death	July		2011 ounty of Death	10:10 PM
			Reeders Memorial Home			Boons					ounty of Death ashingt	
	Funeral Director	·	210-14-2771 1 □ M 2 🔯 F	(In yrs. last		If Under 1 Yea Months Days		der 24 Hrs. s Min.	8. Date of Birt July 11	h , ^Y 27924	9. Birth Penn	place (State or Foreign sylvania
	nd ihow at	or	Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Loca	ation			<u>. </u>	•		10d. Inside City Limits
1	Maryla 28a-f s otified	irect	West Virginia Berkeley	F	alling	, Waters	s					1 ☐ Yes 2 🔀 No
	with the s 23a or s	Funeral Director	10e. Street and Number 38 Phoenix Lane			10f. Zip Code	5419			10g. Citize Unite	n of What Cou d State	ntry? e.s
aret L. 5-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Examed Forces? 1 □ Yes 2 ☑ Never Married 15. Was Decedent Examed Forces? 1 □ Yes 2 ☑ Never Married 16. Was Decedent Examed Forces? 1 □ Yes 2 ☑ Never Married 17. Was Decedent Examed Forces? 18. Was Decedent Examed Forces?	ver in U.S. No		as Decedent of Yes, specify Cu			cify Yes or No- Rican, etc.)		Race - Ameri Black, White, esify: Wh	
arg	within 72 hou giene. er than "natu , the Medica	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5-		(Give kii life. DO	nt's Usual Occi nd of work done NOT use retire Sperso	e during m d)	ost of worki	ng		of Business Ir	
. 12	be filed a ental Hyg ked oth c event,	To Be	17. Father's Name (First, Middle, Last) Emmett McMillan					other's Name	e (First, Middle, nkin	Maiden Sur	name)	
Fisher, 1	d 2 should I salth and Me n 27 is marl er traumati		19a. Informant's Name/Relationship (Type, Print) James W. Fisher / Son		19b. Mailing	Address (Stree	ane,	nber or Rura Falli	Route Number	r, City or Tov	wn, State, Zip V 25419	Code)
E: nore,	age 1 and ent of Heal nt: If item 2 y or other		20a. Method of Disposition 1 □ Burial 2 🕱 Cremation 3 □ Removal from State 4 □ Donation 5 □ Order (Specify)	cerr	netery, crema	tion (Name of tory or other pl Cremat		July 0	13, 113,		tion - City or T	own, State Maryland
NATIE: Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Englishmen (Specify)	Resi	22. R	Name and Add	ress of Fac n Fur	eral	Service	s. Sk	kot Co	ly P.A.
			23a. Part 1. Enter the disease, or complications that caused shock, or head failure. List only one cause on each line.	the death.						_	ederic	Approximate
Į.	Pnysician/ Medical		Immediate Cause (Final disease or condition a.	tdv	lance	dV	ascu	las	Den	revil	9	Interval Between Onset and Death
	≟xaminer	7	Due to (or as a	CR	neb	70 Var	cul	0.77	diso	01/15		
	uted Id ansit	Examiner	Sequentially ist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	consequen	nce of):	esten	215	N				
0	sate be executed physician and the burial-transit	edical Ex	resulting in death) Last Due to (or as a	consequen	nce pt):l	0 - 1						
876	tificate ng phy as the	Medi	IF FEMALE:									
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transitions.	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	2 🔲 Fetal d	leath 3	Ectopic pregna Other (specify)	ncy			230	d. Date of deliv	ery Day Year
s, P.C	res that I signed b	ρ	Part II. Other significant conditions contributing to death bu				given in Pa	art I.	23e. Did to		_	ne cause of death?
cord	aw requias been 2 shoul	Completed							24a. Was a	sy	prior to co	psy findings available mpletion of cause of
I Re	n: The I ificate h or, page		25. Was case referred to medical			26	Diego of D	eath (Check	1 🗆 Yes	rmed?	death?	2 🗆 No
Vita	hysicia his cert I direct	To Be	examiner? 1 Yes 2 Yes Hospital: 1 Inpatier		R/Outpatient	Los			me 5 Resid	ence 6 🗆	Other (Specify)
Division of Vital Records, P.O.	ending P sath. or: After t he funera	Certificate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation		Bb. Time of injury	28c. Inju wo M 1	uryat ork? ☐ Yes 2		28d. Describe h	ow injury oc	ccurred	
Divisi	ital or Att ins after d al Direct led in by t		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injur building, etc.	(Specify)					City or Tow	n, State)		Route Number,
	e Hosp 124 hou e Funer	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of many one of the best of examiner: On the basis of examiner on the basis of examiner. To the basis of examiner on the basis of examiner.	amination ar	nd/or investig	ation, in my opir	nion, death	occurred at	the time, date a	nd place, an	d due to the ca	use(s) and manner stated.
4	To th within To th comp		29b. Signature and title of certifier		MD	29c. Licen	ise numbe	r		29d. Date s	igned (Month,	Day, Year)
			30. Name and address of person who completed cause of dea				06:	323	_3	D	7/12/	11
	2		Dr. Shahid Mahmood 580 No.	rther	n Aven	ue Hag	gerst	own, 1	1D 2174	2 301	L-733-4	496
/	Stat Registra	~	4 6 004d A	's Signature	1. So	arkel						

DHMH 17 Rev 7/2009

Records, P.O. Box 68760 The law requires that the death certificate be executed permit. Page 1 and 2 should be filed within 72 hours after

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death J_{u1y}^{Month} Physician/ Horace Curry Groom, Jr. 2011 11:20 A M Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death **Examiner** 11750 Asbury Circle, Apt. 113 Solomons Calvert 8. Date of Birth (Month, Day, March 3, Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** ^{Year} 1919 1 🔀 M 2 🗆 F Months Days Hours Min. Virginia 214-12-0843 92 Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director 1 ☐ Yes 2 🕅 No Maryland Calvert Solomons be filed within /2 mountental Hygiene.

Inked other than "natural", or items 23a or 28

The event, the Medical Examiner must be not 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20688 United States 11750 Asbury Circle, Apt. 113 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, specify Cuban, Mexican, Puerto Rican, etc. \$ 1 Never Married 2 Married 1 ☐ Yes 2 ₩ No Specify: If Yes, Give Year or Dates Specify: White Completed 3 W Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) Instrument Co. Instrument Technician Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked out any Injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Surname) ည Horace Curry Groom, Sr. Callie Ann Parks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16 Silver Kettle Court, Gaithersburg, MD 20878 Carole Mattis / Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 H Burial 2 Cremation 3 Removal from State St. Paul UMC Cemetery 07/21/2011 Lusby, Maryland 4 Donation 5 Other (Specify) Rausch Funeral Home, P.A. 21. Signatore of Funeral Service Licensee 22. Name and Address of Facility P.O. Box 600, Lusby, MD 20657 23a. Part 1. Enter the disease, or complications that caused the seath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final tive 6004 Physician/ es disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner yeur. themia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami burial-transit and Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical IE EEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death signed by the a d be detached f 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 K certificate 2. No 1 Yes To the Hospital or Attending Physician: after death.

Director: After this certific 25. Was case referred to medica 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 🗌 No Accident
Suicide Investigation 6 Could not be within 24 hours after de
To the Funeral Directo
completed filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 14 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) honles W. Bennett MD D25156 July 18, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 KW

State Registrar 31. Date filed (Month, Day, Year)

JUL 18 2011

32. Registrar's Signature

Charles W. Bennett, MD 11845 H.G. Trueman Rd., Lusby, MD 20657

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Gordon Richard Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany WMHS-RMC Cumberland Birthplace (State or Foreign Country)
 MD If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In vrs. last birthday) Funeral Days Hours Dec 20 1 QM 2 DF Director 215-44-7746 68 Usual Residence of Deceden "natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shon any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits Director Wiley Ford WV Mineral 1 □xYes 2 □ No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral Rt. 1 Box 108 26767 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes, Give Year or Dates white Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday College (1-4 or 5+) Steel Worker Steel Mill Be 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) ဂ္ Mary Elizabeth Laupert Benjamin Gordon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wiley Ford WV 26767 19a. Informant's Name/Relationship (Type, Print) Phyllis Stump sister 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 Donation 5 Other (Specify) Scarpelli Funeral Home, P.A. 7/18/201 MD Cresaptown 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Part Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 3 MoS. Immediaté Cause (Final Physician/ Carcinoma Lung disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine If any, leading to immediate cause. Enter Underlying attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 E FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death ate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 → Yes 2 □ No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, I To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🖵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 2 L 3 L Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ed cause of death (Item 23a) (Type, Print) CUMBERLAND, MD 21502 925

State Registrar 31. Date filed (Month, Day, Year)

2 9 2011

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 305 Golembesky Louise Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany WMHS-RMC Cumberland 5. Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) MD 1 □ M 2 □ 🗜 Months Hours Aug 10, ^{ar)}1<u>947</u> Director 232-74-4561 63 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director MD Allegany Cumberland 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 730 Furnace Street USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?
1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give 3 Divorced white Year or Dates item 27 is marked other than "natur other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Special Education Teacher School System Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Shirley Gilmore John D. Mudge 19a. Informant's Name/Relationship (Type, Print) lailing Address (Street and Number or Rural Route Number, City or Town, State, Zip HC 65 Box 3110 Springfield WV 26763 Cindy Maphis sister 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 remation 3 Removal from State 4 Donation 5 Other (Specify) Scarpelli Funeral Home, P.A. 0 Important: If any injury or 7/22/201 MD Cresaptown 21. Si a ture o Funeral Service Licenses 22. Name and Address of Ferrilly Full Home, PA 108 Virginia Avenue: Cumberland, MD 21502 enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1 Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) Medical Examine Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day 5 Other (specify) 1 Yes 2 9 Unknown 9 Unknown contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been six completed filled in by the funeral director, page 2 should t 1 Yes 2 No 3 Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒️ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🔀 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA မ Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 🗌 Yes 27. Manner of Deatl 28b. Time of 28d. Describe how injury occurred Matural Natural injury 5 Pending 2 🗌 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check

State Registrar only one)

29b. Signature and title of certifier

Mullamma 31. Date filed (Month, Day, Year)

29

2011

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ 12 JULY FAYEZ BATRA HANNA 2011 **P** M 9:31 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner QUEEN ANNE'S **QUEEN ANNE'S EMERGENCY CENTER** QUEENSTOWN 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. 1**X** M 2 □ F Hours 0971071936 **EGYPT** Director 570-92-8527 74 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at filed within 72 hours after death with the Maryland at Hygiene. 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No **QUEEN ANNE'S** STEVENSVILLE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 315 QUEEN ANNE CLUB DRIVE 21666 UNITED STATES 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: WHITE "natural", 3 X Widowed 4 Divorced Completed traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Seconday (0-12) College (1-4 or 5+) OSHA DIRECTOR FEDERAL GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental h. Important: If item 27 is marked of any injury or other traumatic ever once. ဂ္ BATRA HANNA TAFIDA ABADIER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PETER FAYEZ HANNA / SON 208 QUEEN ANNE CLUB DRIVE, STEVENSVILLE, MD 21666 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State CHESAPEAKE CREMATION 1 Burial 2 X Cremation 3 Removal from State 07/14/2011 4 Donation 5 Other (Specify) STEVENSVILLE, MD CENTER 21. Signature of Funeral Service 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A.
106 SHAMROCK ROAD, CHESTER, MD 21619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between 1 DAY Immediate Cause (Final Pnysician/ MYOCARDIAL INFARCTION disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of autopoperformed: death? filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 🗷 No မ 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No X Natural 5 Pending М Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State)

20

MS

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AMIT RAJVANSHI, MD 121 CONGRESSIONAL LANE #409, ROCKVILLE, MD 20852 31. Date filed (Month, Day, Year) JUL 15 2011

State Registrar X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License numbe

D37891

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

JULY 13, 2011

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

			Please	Type or Pri							egible.	
		For State Registrar		State of M	aryland	-	artment of tificate of	Health and I Death	Mental Hy	rgiene Reg. N2 (011	24253
Physicia	n/	1. Decedent's Name Avigai			7				2. Date of D	eath		3. Time of Death
Medic Examin	al			e street and number)	mand	ez	4b. City. Town.	or Location of Death		14,20	unty of Deatl	<u> 5:40a ^M</u>
				Medical			Нуа	ttsville	e	Pr	ince	George's
Funeral Director		5. Social Security No.	8211	Sex 1 □ M 2 🔀 F	e (In yrs. las	t birthday) Yrs.	If Under 1 Year Months Days		8. Date of Bi	rth ¶V,9/e3/)4 	g. Birt E 1 ^{Cot}	hplace (State or Foreign Salvador
ıryland a-f show fied at	ctor	Usual Residence of 10a. State MD	10b. County Montge	omery		Town or Local	Spring	ſ				10d. Inside City Limits
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 Never Marri 3 Widowed	ied 2 Married	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.		"	Vas Decedent of f Yes, specify Cub	Hispanic Origin? (Spoan, Mexican, Puerto E L Salvo Specify:	pecify Yes or No o Rican, etc.) adoran		Race - Ame Black, White ecify: Whi	e, etc.
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permit. Departr Import. any inji		21. Signature of Gu	peral Service Liver	Soulle	-		HULLIPAdu 241 Col	Lumbia B	I FUNE lvd.Si	RAL S lver	ERVIC Sprin	CE,P.A. ng,Md20910
Physician/) Medical Examiner		23a. Part 1. Enter t shock, or hear Immediate Cause (disease or conditio resulting in death)	f failure. List only Final	nplications that caused one cause on each line a	Э.			ing, such as cardiac				Approximate Interval Between Onset and Death
executed an and rial-thrait	Examiner	Sequentially list co if any, leading to in cause. Enter Under Cause (Disease or that initiated events resulting in death) I	nmediate rlying iinjury s	b. Due to (or as	a co u seque	nce of): U	- Jan	WYC .				
ate be e	dical			d								
To the Hospital or Attending Physician: The law requires that the death certificate be exect within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician an agmpleted filled in by the funeral director, page 2 should be detached for use as the burial-after.	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 ₹ 9 ☐ Unknown	months?	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal	death 3	Ectopic pregnal Other (specify)	ncy		23d	l. Date of del Month	ivery Day Year
ires that the signed by Id be detail	þý		ncant conditions	contributing to death b	out not resul	ting in the u	nderlying cause (given in Part I.				the cause of death?
he law requite has beer	Completed	0							24a. Was auto perl 1 Yes	opsy formed?		topsy findings available completion of cause of
ician: T	Be	25. Was case referre examiner?		Hospital:				Place of Death (Che		2 23 110		
ding Physi h. After this of funeral dir	ate: To	27. Manner of Death	5 Pending	1 ☐ Inpati 28a. Date of inju (Month, Da	iry 2	R/Outpatien 8b. Time of injury	28c. Inju	4 Nursing F	fome 5 Res 28d. Describe			ify)
il or Atten s after deat Director: d in by the	Certificate:	2	Investigation 6 Could not Independent	be 280 Place of Inju		ne, farm, stre	eet, factory, office			(Street and Nu wn, State)	ım ber or Rui	ral Route Number,
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within		29b. Signature and	title of certifier	2 V2		•		se number 20636 &	,	29d. Date si	gned (Month	n, Day, Year)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 13, 2011 Norma L. Hurley 7:58 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Genesis Elder Care Charles LaPlata If Under 1 Year If Under 24 Hrs. . Social Security Number 8. Date of Birth g. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Year) ec. 5, 1933 Days Hours Min. 1 □ M 2X F Wisconsin 214-30-1418 Director 77 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 1 Yes 2 No Nanjemoy Marvland Charles 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 1990 Liverpool Point 20662 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. "natural", or ρ 1 Never Married 2 Married 1 Yes 2 No Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify: White 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 721 nand Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Charles Co. Board of Ed. Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unseth Leo L. Buckbee Dagny permit. Page 1 and 2 should be Department of Health and Men Important; If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5510 Grinder Rd., Marbury, Md. 20658 Bonnie Johnson Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) July 19, 2011 20a. Method of Disposition 20c. Location - City or Town, State 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Nanjemoy, Maryland Nanjemoy Baptist Church Cemetery 21. Signature of Funeral Sen Williams Funeral Home, P.A. M00668 4270 Hawthorne Rd., Indian Head., 23a. Part 1. Efter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line.

Immediate Cause (Final Onset and Death nysician Respirator disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence or) Cause (Disease or linjury that initiated events resulting in death) Last and tran Due to (or as a consequence of): attending physician for use as the buria Physician/Medical certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☑ No Month Year Day Pregnant at time of death ned by the a 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ No 3 Probably 4 Unknown 1 Tyes Completed peen 24b. Were autopsy findings available 24a. Was an Hospital or Attending Physician: The law prior to completion of cause of death? autopsy performed this certificate has page 2 1 Tes 2 No director, 25. Was case referred to redical 26. Place of Death (Check only one) Be examiner? Other: ဂ 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 1 Natural 5 Pending injury work?
1 Yes 2 No ☐ Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) aemees do 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DOMU 31. Date filed (Month, Day, Year) 32. Regist - s Signature State JUL 18 201

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended 10e1 - State Registrar 19b, 7/12/11, M.S. Kent Co. Certificate of Death cedent's Name (First, Middle, Last) 2. Date of Death Physician/ 150r 0402 AM 201 10 Medical Examiner 4c. County of Death Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗶 F Months Days Hours Min. (Month, Day, Year)
MARCH 5 214-28-3122 Director MARYLAND 79 1932 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No MD KENT CHESTERTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Tolchester Beach Rd. Funeral TOULCHESTER BEACH RD. 21620 21771 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 X No Specify. "natural", Specify: BLACK 3 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 n and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) C.N.A. MEDICAL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev VINCENT GRINNELL MINNIE THERESA JACKSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tolchester BEACH RD. CHESTERTOWN, MD 21620 VIOLET ROSE/DAUGHTER Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 😿 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION 7-11-2011 CHESTER, MD 21. Signature of Funeral Service Lice 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME
130 SPEER RD. CHESTERTOWN, MD 21620 23a. Pa 1. Enter the disease, or complication: that caused the dept shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final DULMONA EMBOLUS Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury CHRON iC OSSMUCTIVE DISETSE burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical certificate be Box 68760 the IF FEMALE USB 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 9 Unknown 5 Other (specify) Month Day Year 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Records. Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2- No certificate or Attending Physician: 25. Was case referred to medical Division of Vital director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes Inpatient 2 ER/Outpatient 3 DOA မ funeral Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be after death filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital within 24 hours a To the Funeral L Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier сопретер (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0071130 (30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STREET CHESTERTSUN 100 BRown RM ALOBS MD 31. Date filed (Month, Day, Yes 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	4	For State		S	tate of	f Maryla	nd / Depa	artmen <i>tificate</i>			and M		1	ווחי		242	56
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Physician	/	1. Decedent's Name (F	iist, middie	. ,				T 1.7	ar ti			Month	Day	Year		3. Time of I	
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/	4	Frederic 5. Social Security Number		Orla上 6. Sex			last birthday)	ドア If Under	eder 1 Year	1CK	24 Hrs. T	8. Date of Bir				ace (State or	Foreign
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nd M	1	19a. Informant's Name Elizabeth M	/Relations	nip (Type, P	zint) 1	.	19b. Mailir	na Address	(Street a	nd Numbe	r or Rura	Route Numbe	er, City or T	own, State, Z	Zip Co	nde)	
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1 and if Her othe	寸	20a. Method of Disposi				20b.	Place of Dispo					ate	20c. Loc	ation - City	or Tow	n, State	
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Phys this ral dii	<u>ا</u>	27. Manner of Death	10		1 X I 8a. Date d		ER/Outpaties 28b. Time of		Bc. Injury	4 ⊔ Nι		me 5 🗆 Resid			ecify)		
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to the within To the complete		29b. Signature and title				- 110 DOGE OF T			License	number		-, 445 10 111		signed (Mon			
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10		30. Name and address	of person		eted cause	of death (Ite	m 23a) (Type, F	Print)	<i>use</i>	Ave	. /	rederi	cle.	MO) _	2170	/
State		31. Date filed (Month, E	Day, Year)	4 2011	32. Re	strar's Sign	ature	bas Ka	,		, ,				0		•
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Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien

			For State Registrar	tate of Maryland / De	epartment of He Certificate of De	aith and Me eath	ental Hygier Reg. l		24257
	Physicia		1. Decedent's Name (First, Middle, Last) SADIE IRBY	JACKSON			2. Date of Death U1y 12	2011 Year	3. Time of Death 1350P M
1	/Medic Examin		4a. Facility Name (If not institution, give street		4b. City, Town, or Lo			4c. County of Deat	
14,	Funeral		HOLY CROSS HOSP 5. Social Security Number 6. Sex 1 □ M	7. Age (In yrs. last birtho	7/		B. Date of Birth (Month, Day, Ye	Iontgome 9. Birtle	ery pplace (State or Foreign untry) S.C.
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	death with the Maryland me 23a or 28e-f ehow rmust be notified at	J.	10a. State 10b. County D. C.	10c. City, Town o					10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	r 28e-f	Director	10e. Street and Number	Washin	10f. Zip Code		10g.	Citizen of What Co	untry?
	th with		868 Burns Stree	t, S.E.	20019			U.S.A.	
36	be filed within 72 hours after death with the Marylar ital Hygiene. d other then "natural", or iteme 23a or 28e-f ehow event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 12. 12. 12. 12. 13. 14. 15. 15. 15. 15. 15. 15. 15. 15. 15. 15	Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give T Year or Dates:	13. Was Decedent of Hisp If Yes, specify Cuban, 1 ☐ Yes 2 ☒ No		rfy Yes or No- ican, etc.)	14. Race - Ame Black, White Specify:B1 a	e, etc.
2-00	72 hou natura		15. Decedent's Education (Specify only highest grade co		ecedent's Usual Occupation Give kind of work done during the common section of the comm	on ring most of workin	16b	. Kind of Business/	Industry
Maryland 21215-0036	within ene. then "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	te. DO NOT use retired) cher			Public	School
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Za	2 should be and Mental is marked of aumatic ever	10	John Irby	7		da Bell		ean	7: O-d-)
Ma	- E N =		19a. Informant's Name/Relationship (<i>Type</i> , Ernest Todd c		Mailing Address (Street and				20018
Baltimore,	pes 1 and 2 of Health If item 27 or other tra		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Remo	20b. Place of D	2.2.5 guth. Disposition (Name of crematory or other place)			Location - City or	own, State
Ē	permit. Pages Department of tmportant: If it eny injury or o		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Ligensee	Lincol	n Memoria1 22. Name and Address	of Facility			Maryland—
Ba	Depa tmpo eny i		16.1. 16	Suit		HAL			ERAL HOME
			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one complications are complicated as the complex of the com				respiratory arrest,	Washing	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence of)					
4	Examiner		Sequentially list conditions	Breast Cancer		stasis			
٠.	pe jisi	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of) Multiple Myel					
oʻ.	ificate be executed g physicien and as the burial-transit	Examine	that initiated events resulting in death) Last	Due to (or as a consequence of)					
98760	icate be physicies s the bu	edlcal	d						
Box 6		n/Me	IF FEMALE: 23c. 23c.	If yes, outcome of pregnancy	·			23d. Date of del	ivery
oj.	0 0 0	Physician/M	in the past 12 months?	1∏Live birth 2 ∏Fetal death 4∏Pregnant at time of death 9∏Unknown	3 □Ectopic pregnancy 5 □ Other (specify)			Month .	Day Year
rds, P	es this	by	Part II. Other significant conditions contrib	uting to death but not resulting in th	ne underlying cause given	in Part I.	23e. Did tobaco		o the cause of death? obably 4 Donknown
Vital Records,	has b	Completed					24a. Was an autopsy performed 1 Tyes 2 D	prior to death?	utopsy findings available completion of cause of 2 No
/ital	ician: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?			26. Place of Death	U	12.100	25110
ö	Phys this ral dii	2	1 ☐ Yes 2 DNo Hosp	1 P Inpatient 2 LEN/Outpa	atient 3 DOA Other:	4 Nursing Hom	e 5 Residence	6 ☐Other (Spe	cify)
lo I	Attending I or death. ector: After by the funer	atlor	1 Natural 5 Pending 2 Accident investigation	8a. Date of Injury (Month, Day Year) 28b. Tim Inju	iry Work?	s 2 No		,,	
Division	i Difte	Certification:	3 Suicide 6 Could not b 4 Homicide determine 2	8e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office	2:	Bf. Location (Stree City or Town, S	t and Number or Ri tate)	ural Route Number,
	9 4 7 9 9 9 9 y	edical (29a. Certifier (Check only one) 1 Certifying Physicis 2 Medical Examiner:	on: To the best of my knowledge of On the basis of examination and/or and manner stated.	seth occurred at the time or investigation, in my opin	date and place and nion, death occurre	nd due to the name d at the time, date	e(s) and trainer at and place, and due	stated to the cause(s)
	To the within 2. To the complet	Me	29b. Signature and title of certifier	0 0 -	29c. License r			Date signed (Mont	
•	7	1	30. Name and address of person who compl	M /// () /		065	JI	1	
	3		Dr. Kanwaljit N	agi 1500 Fore	est Glen Ro	oad, Si	lver Sp	ring, M	20910 aryland
	Sta Registr		JUL 1 8 2011	32. Registrar's Signature					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) Month Johnson **Physician** 2011 328 JUIN Allvia /Medical 4c. County of Death 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death Examiner The Johns Hopkins Hospital Baltimore City Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours 1 □ M 2X F 22, 748-91-4663 21 June 2011 Maryland Director Usual Residence of Decedent ould be filed within 72 hours after death with the Maryland Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10b. County ms 23a or 28a-f show must be notified at 1 Yes 2XXNo Director Maryland Anne Arundel Churchton 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number USA 20733 5544 Exeter Street Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status "natural", or iter edical Examiner 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify Specify. ⋛ 3 Widowed 4 Divorced Black Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Medical (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. J other than " event, the Mer Elementary/Secondary (0-12) College (1-4 or 5+) n/a n/a 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked Lorenzo Michael Johnson Karen Ann Lee 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trat once. 5544 Exeter Street, Churchton, Maryland 20733 Karen A. Johnson/ Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Kalas Crematory 7/14/11 Edgewater, Maryland 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Dissemineted intravascular Coagulation **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Pulmonary hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Congenital diaphragmatic herma The law requires that the death certificate be executed and Il-tran Due to (or as a consequence of) iding physician a use as the burial Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 - Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) 2 No 9 Unknown Division of Vital Records, P.O. 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I ۵ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy certificate has page 2 No 2 🗌 No 1 Yes Yes or Attending Physician; 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Hospital: 1 Yes 2 No Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA P this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: eral Director: After filled in by the fune 5 Pending investigation 1 Natural Injury 1 🗌 Yes 2 🗌 No 2 Accident death. Could not be determined 3 🗌 Suícide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) 4 🗌 Homicide after the Hospital within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number ٥ JUN 13, 2011 Kes 000

Registrar DHMH 17 Rev 1/2001

State

600 North Wolfe St, Baltimore, MD, 21287

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Redistrar's Signature

Yang

JUL 14 2011

Mris 31. Date filed (Month, Day, Year)

ND#1 per HIY State of Maryland / Department of Health and Mental Hygiene 7/14/2011 AACO HEALTH DEPT. CMH Certificate of Death For AM State Registrar Certificate of Death Reg. No Princess May Fernandez Johnson 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician/ Year 1325 11 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** N/A Medical Booltimore University Maryland Center of 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Funeral Month, Day, Feb. 23 1 🗆 M 2 🕮 Months Days Hours Min. 233-42-2041 83 1928 West Virginia Director Usual Residence of Decedent 28a-f show 10b. County 10a, State 10c. City, Town or Location notified at 10d. Inside City Limits Director 1 Yes 2 No Anne Arundel Annapolis 10e Street and Number or 10f. Zip Code 10g, Citizen of What Country? Examiner must be items 23a USA 916 Perry Landing Ct. 21401 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 0 þ ☐ Yes 2 🗷 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify. White "natural" 3 ₩ Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Anthony Putinsky Ora Casey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Mary J. Fernandez / Daughter 16317 Bawtry Ct., Bowie, MD 20715 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 7/14/2011 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityBeall Funeral Home Bowie, MD 20715 6512 NW Crain Hwy 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Cerebral herniation disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner hours ntracranial Sequentially list conditions Examine any, leading to immediate cause. Enter Underlying Due to for early rominactioning of as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed hours brain Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of) attending physiciar Physician/Medical 26 tall hours Box 68760 IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) for in the past 12 months?
1 Yes 2 No Month Dav Year signed by the a g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed certificate 2 🗌 No 1 Tes Yes 2 No ours after death. eral Director: After this certific filled in by the funeral director, of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes Hospital Other: 2 🗌 No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred __AL (Month, Day, 5 Pending Year) injury 1 Natural Division ln/n0900 М 2 🛮 No & unresponshe by EMS Accident Investigation down Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Lural Route Number, City or Town, State) 4 Homicide determined lome Perry Landing CT. Amazolis MD 24 hours Funeral Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier сотріете (Check To the 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only on of certifie 29b. Signarur DONALD MARRISME Name and address of person who completed cause of death (Item 23a) (Type, Print) Harris 5. Greene 22 31. Date filed (Month, Day, Year) Registrar's Signature State 1 4 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 24260 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day 2011 Physician/ July 10, Jackson 11:10A M Winifred Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Frederick Golden Living 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Hours (Month, Day, Year) Feb 27, 1917 1 M 2 XF Months 94 Iflinois 212-22-5049 Director Jsual Residence of Decedent 28a-f shov aţ 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Silver Spring Examiner must be notified Montgomery 1 ☐ Yes **XX**No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 23a USA 20906 3330 N. Leisure Boulevard items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 0 þ 1 Never Married 2 Married 1 ☐ Yes 2 💥 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 N Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ e 1 and 2 should be for the form of Health and Menta fitem 27 is marked rother traumatic even Kathryn Welker Fleetwood Corwin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kimberly Molineu - granddaughter 6647 E. Lakeridge Road, New Market, Maryland 21774 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or or ò 1 Burial 2 X Cremation 3 Removal from State Stauffer Crematory 7-14-2011 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Si vature of Funeral Serv v Licensee 22. Name and Address of Facility Stauffer Funeral Home came 21704 1621 Opossumtown Pike, Frederick, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ ETE BROUASCULAR disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner DEMENTIA Sequentially list conditions. cause. Enter Underlying Cause (Disease or linjury Due to for as a consecutivity of Exami requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician a s the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown has been si e 2 should b Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law 24 hours after death. autopsy page certificate 1 ☐ Yes 2 ☐ No Yes æ 25. Was case referred to medica 26. Place of Death (Check only one) Hospital Other: 2 No ည 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Deat 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 1 Natural 28c. Injury at 28d. Describe how injury occurred iniury work? 5 Pending s after death.

I Director: Af d in by the fur 2 🗌 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State

29b. Signature and title of certifier

31. Date filed (Mont)

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

MO

KAZMI

8-14

Registrar's Signature

ASEA.

Toll House Aut.

29d. Date signed (*Month*, *Day*, *Year*)

FREDERICK - MD 21701

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			101	partment of Health and N	/lental Hygie	2011	24261
			Registrar 1. Decedent's Name (First, Middle, Last)	ertificate of Death	Reg 2. Date of Death	NE UII	
	Physicia		Wyvon William King, Sr.		July 13,	Day2011 Year	3. Time of Death 4:58 ам
-	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
age of the			4029 Adams Drive	Silver Spring		Montgomer	ry
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,		8. Date of Birth (Month, Day, Ye		place (State or Foreign MD
	Director		577-30-1507 Tax M 2 F 84 Yrs. Usual Residence of Decedent		Nov. 18,	1926	~MD
	and show at	o	10a. State 10b. County 10c. City, Town or L	ocation		1	0d. Inside City Limits
	√aryla 8a-f s tified	Director	MD Montgomery Sil	ver Spring			1 🗆 Yes 2 🛚 No
	a or 2 be no		10e. Street and Number	10f. Zip Code	10g	g. Citizen of What Cour	ntry?
	h with	Funeral	4029 Adams Drive	20902		USA	
336	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 □ Never Married 2 Married 1 □ Never Married 2 Narried 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 No If Yes, Give 1944–47 Vaar or Dates.	Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Whit	etc.
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Baltimore, Maryland 21215-0036	d 2 shoul alth and 1 1 27 is ma		i i	ling Address (Street and Number or Rura Adams Drive, Silv			
more,	age 1 an ent of He nt: If iten y or othe			amatory or other place)	1 7 18	c. Location - City or To	
3altir	permit. P Departm Importar any injur		21. Signature of Funeral Service Licensee	Panamerand Address of Ficilitins	Funeral H	ome Inc	
	συ = m ο			00 University Blvd			
+	Physician/		shock, or heart failure. List only one cause on each line. Immediate Cause (Final lisease or condition Parkinson's Disea		or respiratory arrest,		Approximate Interval Between Onset and Death
	Medical Examiner		resulting in death) Due to (or as a consequence of): Sequentially list conditions				
	of red	dical Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (pisease or imjury				
	icate be executed g physician and is the burial transit	al Ex	that initiated events c. Due to (or as a consequence of):				
760	cate to physical controls in the level of th	ledic	d				-
Box 687	th certif ftending or use a	Physician/Me		☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of deliver	ery Day Year
P.O.	ires that the dea signed by the a id be detached f	, Phy	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	co use contribute to the	ne cause of death?
ds, F	v requires the been signer should be a	ed by			1 🗌 Yes	2 🔀 No 3 🗆 Prof	bably 4 🗆 Unknown
Division of Vital Records,	s ician: The law red s certificate has ber lirector, page 2 sho	Completed			24a. Was an autopsy performe	prior to co d? death?	osy findings available mpletion of cause of
a	ian: T	Be C	25. Was case referred to medical examiner?	26. Place of Death (Check		24140	
Ξ	hysic his ce	10	1 ☐ Yes 2 ☐ Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpati		ome 5 Residenc	e 6 Other (Specify)
on of	Attending Physician: The la redeath. ector: After this certificate he by the funeral director, page	Certificate:	27. Manner of Death 28a. Date of injury 28b. Time 1 1 2 2 2 2 2 2 2 2	of 28c. Injury at work? M 1 □ Yes 2 □ No	28d. Describe how i	injury occurred	
Divisi	ial or Attender's after deat al Director: ed in by the	I Certi	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	reet, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural State)	Route Number,
_	To the Hospital or A within 24 hours after To the Funeral Direct completed filled in by	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death of the desired for	stigation, in my opinion, death occurred at	t the time, date and p	place, and due to the car	use(s) and manner stated.
	Withi Withi	ŀ	29b. Signature and title of certifier Purpose Signature and title of certifier	29c. License number		Date signed (Month, 1	
	•		30. Name and address of person who completed cause of death (Item 23a) (Type, Christopher Mays, MD 18111 Prince				
	Stat Registra	e ar	31. Date filed (Month, Day, Year) 32 Registrar's Signature JUL 15 2011				

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

			Please	Type or Pri						-		egible.	
		For		State of M	arylan		artment of H		and Me	ental Hyg	giene		01000
		StateRegistrar				Cer	tificate of L	Death		F	Reg. No		24262
Physicia		-	e (First, Middle, Last	-FRED	KE	NDA	u Jr		2	2. Date of Dea Month	th Day	Year	3. Time of Death
Medic Examin			not institution, give s	street and number)		7.	4b. City, Town, or		of Death のW시	1		unty of Death	
Euroval		5. Social Security No				ıst birthday)	If Under 1 Year	If Under		3. Date of Birth			hplace (State or Foreign
Funeral Director		218-48-8 Usual Residence of	8223	M 2 □ F	64	Yrs.	Months Days	Hours		MAY 22	Year) 94	7 Since	intry) IARYLAND
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or 28	Ę.	10e. Street and Nun			WUK	ION	10f. Zip Code				10a Citizen	of What Co	
vith ti	Funeral Director	25000 T	AMBS MEADO	מע עו			21678				USA		anay.
ath v	nue	11. Marital Status	ALDO FILADO	12. Was Decedent B	ver in U.S	S. 13. V	Vas Decedent of H	ispanic Ori	igin? (Specif	v Yes or No-		Race - Amer	ican Indian
or ite	by F		ied 2 Married	Armed Forces?	No.	11	f Yes, specify Cuba	n, Mexicar	n, Puerto Rio	can, etc.)		Black, White	
s afteral",		3 Widowed	4X Divorced	If Yes, Give - Year or Dates		69 1	☐ Yes 2 No	Specify:	<i>'</i> :		Spe	ecify: WHI	TE
hour natu dical	Completed	(0	15. Decedent's Ed	ucation		16a. Deced	lent's Usual Occup			- 1	16b. Kind	of Business I	ndustry
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ld be Ment arke	입	ERNEST A	ALFRED KEN	NDALL, SR.	,			ETH	EL EL	IZABET	H WAT	SON	
shou and is m		19a. Informant's Na	me/Relationship (Typ	oe, Print)		19b. Mailin	g Address (Street a	and Numbe	er or Rural R	Route Number,	City or Tou	ın, State, Ziç	Code)
nd 2 ealth m 27 ner tr			DIANNE AN	NDERSON/PO)A	2500	O LAMBS 1	MEADO	W RD.	WORTO	N, MD	21678	
of H of H if ite		20a. Method of Disp	oosition Cremation 3	Damoval from State			sition (Name of natory or other plac	e)	Dat	te	20c. Locat	ion - City or	Town, State
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		4 Donation	5 Other (Specify)			E CREMAT		7-12-	2011	CHEST	CER, M	D
permit. Depart Import any inj once.		21. Signature of Fur	neral Service License			22	Name and Addres	s of Facilit	WRETN	s nem	TA MAD	INFRAT	HOME P.A.
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		shock, or hear	he disease, a comp t failure. List only on	ications that caused ause on each line	the death	n. Do not ente	r the mode of dyin	g, such as	cardiac or r	espiratory arre	est,		Approximate Interval Between
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bour: hour: nera d fille	Medical	29a. Certifier 1	Leertifying Physi	cian: To the best of	my knowle	edge, death o	ccured at the time,	date and	place, and c	due to the cau	se(s) and m	anner as sta	ted.
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the	Med		☐ Medical Examin ☐ Certifying Nurse										ause(s) and manner stated. stated.
Vith Com		29b. Signature and t	tine of certifier	0			29c. License	number		<i>f</i> . 2	9d. Date sig	gned (Month	, Day, Year)
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+		30. Name and addre	1 /		eath (Item	23a) (Type, P	rint)						-
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Stat Registra	C .	31. Date filed (Month	n, Day, Year)	32. Registra	r's Signati	ure J.	por						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 24263 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ GLADYS MARIE GLANDING KINCAID JULY \mathbf{A}^{M} 10. 2011 4:10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 2905 SUDLERSVILLE RD. SUDLERSVILLE QUEEN ANNE'S If Under 24 Hrs. Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days 1 □ M 2 🕱 F 8-11-1934 214-34-5033 Yrs **Director** MARYLAND 76 Usual Residence of Decedent at 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director must be notified 28a-1 1 Yes 2 X No MD QUEEN ANNE'S SUDLERSVILLE 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? Funeral 23a 2905 SUDLERSVILLE RD. 21668 USA ral", or items? Examiner mus death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Force Black, White, etc. 0 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Completed by filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: 'natural", Specify: 3 X Widowed 4 Divorced WHITE Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 8 ENVIRONMENTAL SERVICES ASSISTED LIVING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental f 1 and 2 should be fill of Health and Mental item 27 is marked ပ THOMAS GLANDING HATTIE GLANDEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) REGINA CROSSLEY/DAUGHTER 905 RACE TRACK RD. SUDLERSVILLE, MD 21668 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 permit. Page 1
Department of Important: If it any injury or o once. 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Donation 5 Other (Specify) SUDLERSVILLE CEMETERY 7-13-2011 SUDLERSVILLE, MD Sign fure of Funeral Service Licer 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME P.A.
370 W. CYPESS ST. MILLINGTON, MD 21651 Part 1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): -transit Cause (Disease or iinjury that initiated events resulting in death) Last Exal and Due to (or as a consequence of): burialattending physician for use as the buria Physician/Medical that the death certificate be 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregnancy
5 Other (specify) the past 12 months? Month Day Pregnant at time of death the detached Unknown 9 Unknown P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use combute to the cause of death? þ Records, Hospital or Attending Physician: The law requires 2 No 3 □ Probably 4 □ Unknown Completed 1 🗌 Yes page 2 should Were autopsy findings available 24a. Was an has autops, performed prior to completion of cause of death?
1 ☐ Yes 2 ☐ No ours after death.

eral Director: After this certificate I filled in by the funeral director, page Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 🗹 No Other: မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural injury 5 Pending Accident Suicide Μ 2 Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Sertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one 29b. Signature and title of certifie ٥ 29d. Date signed (Month, Day, Year) 36054 30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 24264 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 2011 Year Junth 9:45 A M Elizabeth Koliopoulos 7, Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3213 Marcando Lane Upper Marlboro Prince George's If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Virginia 218-54-7088 1 🗆 M 2 🕱 F 0871671949 61 **Director** Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits at Director r 28a-f st notified 1 Yes 2 KNo Prince George's Upper Marlboro Maryland 10e. Street and Number 10g. Citizen of What Country? must be r Funeral 20774 3213 Marcando Lane USA within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14 Race - American Indian "natural", or iter edical Examiner Armed Forces? Black White etc. ò 1 Never Married 2XXMarried If Yes, Give Year or Dates. 1 ☐ Yes 2xxNo Specify: White 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12th College (1-4 or 5+) and Mental Hygiene. is marked other tha Billing Administrator Healthcare event, 1 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fill Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve ٥ Theodore Marie Novello Casazza 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nicholas Koliopoulos/Husband 3213 Marcando Lane Upper Marlboro, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1XX Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Vet. Cem. 07/14/2011 Cheltenham, Maryland 22. Name and Address of Facility George P. Kalas Funeral Home PA 6160 Oxon Hill Road Oxon Hill, Maryland Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ DEDIOVASCULAR disease or condition Medical resulting in death) **Examiner** ATTHOSCULOR Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): and Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical IF FFMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Year Pregnant at time of death 9 Unknown 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by The law requires 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 Yes 2 No Yes 2X X No Hospital or Attending Physician: 724 hours after death. Funeral Director: After this certifics 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 X Yes 2 No Other: မ ER/Outpatient 3 DOA 1 Inpatient 2 I 4 Nursing Home 5XX Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes Certificate: 28b. Time of 28d. Describe how injury occurred 1 XXNatural injury 5 Pending Accident 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 🖾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

• • •

Baltimore, Maryland 21215-0036

Box 68760

Division of Vital Records,

DHMH 17 Rev 7/2009

State Registrar 29b. Signature and title of certifier

David T. Isaacs

31. Date filed (Month, Day, Year)

JUL 13 2011

5801 Allentown Rd.

Jacun

32. Registrar's Signature

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Mor

#510 Camp Springs, MD

th, Day, Year) 2011

20746

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ CRAVER KRUHM ALICE _P M Tulv 201 5:21 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Alfred House Elder Care Rockville Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🕱 F (Month, Day, une 25 Months Days Hours Min. 219-12-4443 88 **Director** June ľ923 Marvland Usual Residence of Decedent 28a-f show 10a. State 10b. Count within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director Md. Montgomery Brookeville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 9 10g. Citizen of What Country? Funeral items 23a 3001 Damascus Road 20833 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 6 þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify: White Specify "natural", Completed 3 🔀 Widowed 4 🗌 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pearle V. Burns Allen B. Craver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rita F. Kruhm / Daughter 20905 2140 Edgeware Street, Silver Spring, Md. 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State Brookeville, injuny Salem Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 7/18/11 Signature of Funeral Service Licensee Name and Address of Facility
Muriel H. Barber Funeral Home 20882 0 Box 5038, Laytonsville 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph sician/ Malignant Neoplasm, Breast disease or condition resulting in death) Medical Due to (or as a consequence of): ≟xaminer Advanced Senile Dementia Sequentially list conditions. Examine riany, reading to immediate cause. Enter Underlying Due to (or as a consequence of, attending physician and I for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? 1 ☐ Yes 2 🖪 No Month Dav Year Pregnant at time of death signed by the at d be detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed' certificate Yes 2 YN 2 🗌 No 1 Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 🗷 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🗹 Natural 5 Pending 1 Yes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide determined

Baltimore, Maryland 21215-0036 the Hospital or Attending Physician. The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 within 24 hours after death.

To the Funeral Director: A completed filled in by the fu

> Registrar DHMH 17 Rev 7/2009

State

Medical

29a Certifier (Check

29b. Signature and title of certifier

Lisa Ng,

31. Date filed (Month, Day, Year)

m,D

M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D 0055931

29d. Date signed (Month, Day, Year)

20832

July 8, 2011

3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

4000 Olney-Laytonsville Road, Olney, Md.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep			~ ~ 1 1	21.266
			Registrar 1. Decedent's Name (First, Middle, Last)	rtificate of Death	Reg. I	1020	24266 3. Time of Death
	Physicia Medio		John R. Kashmer	e	July 11,	Day 2011 Year	5:25 A M
	Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4	1c. County of Death	
محمييت	Funeral	۸ .	8012 Daniel Drive 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Forestville If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Prince G	eorge 'S
	Director		170-26-8420 1 ™ 2 □ F 79 Yrs.	Months Days Hours Min.	June 20, I	932 Penn	ntry) isy1vania
	how at	ır	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lc	ecation		- I	10d. Inside City Limits
	Aarylar 8a-f s tified	Director	Maryland Prince George's Foresty	ille			1 ☐ Yes 2 🕱 No
	a or 2 be no	al Di	10e. Street and Number	10f. Zip Code 20747	10g.	Citizen of What Cou	intry?
	ath with	Funeral	8012 Daniel Drive 11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Spe	cify Yes or No-	USA 14, Race - Ameri	can Indian
ဖွ	ter dez , or ite ıminer	by Fi	1 Never Married 2 X Married Armed Forces?	If Yes, specify Cuban, Mexican, Puerto □ Yes 2 🋣 No Specify:	Rican, etc.)	Black, White,	etc.
9	ours af itural" al Exa	eted	3 Wildowed 4 Divorced Year or Dates.				
715	היל 27 ה an "na Medic	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of workl O NOT use retired)	ng	Kind of Business Ir	
21	1 withir ygiene her th rt, the	Be Co	4 Schoo	1 Teacher		-	ge County
land	d be filed Aental H Irked ot Itic even	To B	17. Father's Name (First, Middle, Last) George Kashmere	Josephin	e (First, Middle, Maide ne Sitar:		
Man	d 2 should alth and N 27 is me er trauma			ng Address (Street and Number or Rura Daniel Dr. Forest			Code)
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at one.		20a. Method of Disposition 1	matory or other place)	Date 20c. 20c. E1	Location - City or T	
Balti	permit. I Departm Importa any inju	()(21. Signature f Funeral Service Licenses 2:	2. Name and Address of Facility Geo	rge P. Kal	as Funer	al Home PA
			23a. Part 1. Enter the disease, or complications at caused the death. Do not ent	er the mode of dying, such as cardiac c	r respiratory arrest,		Approximate Interval Between
	nysician Medical	1	Immediate Cause (Final disease or condition resulting in death) a. end Slage Couga a.	estive heart fa	eiluve		Onsepand Death
	Examiner		Immediate Cause (Final disease or condition resulting in death) a. Pud Slack Couga Due to (or as a Insequence of): Sequentially list conditions,	org failure			7 Syears
	sit sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): Choung underlying the consequence of the consequ	Februllehon		,	Syears
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687	ertifica iding p se as t	/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of deli	venv
. Box 687	ires that the death certifical signed by the attending is doe detached for use as	Physician/Me	in the past 12 months? 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)		Month	Day Year
s, P.O.	s tha gned be de	by	Part II. Other significant conditions contributing to death but not resulting in the Covonary avky described. Diabete, Mellivs type II	underlying cause given in Part I.			the cause of death?
ord	w requisibles been 2 shou	Completed	Diabete, Wellites type II		24a. Was an autopsy		opsy findings available ompletion of cause of
Bec	The la	Com			performed?	death?	2 No
ţ	ician: certific rector,	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Innesticat 3 FR/Outration	26. Place of Death (Check			
of V	g Phys er this neral di	te: To	27. Manner of Death 28a. Date of injury 28b. Time o	nt 3 □ DOA	me 5 Residence 28d. Describe how inj		fy)
ion	tendin leath. lor: Aft the fur	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	work? M 1 ☐ Yes 2 ☐ No			
Division of Vital Records,	al or At s after o		4 Homicide determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office	28f. Location (Street a City or Town, Sta		al Route Number,
	To the Hospital or Attending Physician: The law require within 24 hours after death. To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death 2 Medical Examiner: On the basis of examination and/or investoring only one) 3 Certifying Nurse Practioner: To the best of my knowledge,	stigation, in my opinion, death occurred at death occurred at the time, date and place	the time, date and pla e, and due to the caus	ce, and due to the c	ause(s) and manner stated.
			29b. Signature and title of certifier Men 6. Receiptele wis	29c. License number D 0042049 Print) Print) Print) May21 bovo	29d. I	Date signed (Month,	Day, Year)
_	474,0×		30. Name and address of person who completed cause of death (Item 23a) (Type, I Alain 6. Champalous WD U	pper Marelboro	MO	20	772,
	Stat Registra		31. Date filed (Month, Day, Year) JUL 13 2011 32. Registrar's Signature	back			

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		Registrar 1. Decedent's Name (First, Middle, La	st)		Certiff	cate of De	- au i	2. Date of Death	eg. No.		3. Time of Death
Physicia Medic		Josephine 1	Leona LeI	onne				Month 07	89	Year	1851 M
Examin		4a. Facility Name (if not institution, give				•	ocation of Death		4c. Count	ty of Death	
Funeral	М	Anne Arundel I 5. Social Security Number 6. S	Medical C	Center e (In yrs. last birth		Annapo Under 1 Year	lis If Under 24 Hrs.	8. Date of Birth		e Arı	ande l
Director		219-12-550/	□ M 2 K F		Yrs. Mo	nths Days	Hours Min.	02/26/	^{Year)} 1925	Mars	zland
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be filed within 72 hours after death with the Maryland ental Hyglene. Ked other than "natural", or items 23a or 28a-f sho ic event, the Medical Examiner must be notified at	al Di	10e. Street and Number			10	of. Zip Code		, 1	0g. Citizen of		ry?
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permit. Page 1 and 2 should be filed within 72 hours afti Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exa once.		20a. Method of Disposition 1 Burial 2 K Cremation 3		OHIUGEL.	EAKE	(Name of	IM		20c. Location	•	
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sician: The law I certificate has to irector, page 2 s	Be Co	25. Was case referred to medical				26. Plac	e of Death (Chec	1 Yes 2	No	1 🗆 Yes	2 ∐ No
nysicia lis cer direct	To B	examiner? 1 Yes 2 No	Hospital:	ent 2 ER/Ou	tpatient 3	Other		ome 5 Reside	nce 6 🗆 Ot	her (Specify)	
ding Pł J. After th funeral	ate:	27. Manner of Death 1 Natural 5 Pending	28a. Date of inju (Month, Day		ime of njury	28c. Injury a work?	at es 2 🗆 No	28d. Describe ho	w injury occu	rred	
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ne Hos in 24 ho ne Fune pleted i	Medical	(Check 2 Medical Exam		xamination and/o	r investigati	on, in my opinion,	death occurred a	t the time, date and	d place, and d	lue to the cau	se(s) and manner stated.
To the within the transfer of		29b. Signature and title of certifier	101	2nda	w	29c. License r	7 1 4	138 2	Date sign	ed (Month, E	20 []
40		30 Name and address of person who	completed cause of d	eath (Item 23a) (Type, Print)	4100	YENSE	Hwy	ANN	A.PUL	1) MD21401
-				. 7 /							

State Registrar

JUL 1 3 2011

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Down B. park

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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		For State Registrar		State of M	iaryiand	•	artment of F rtificate of L			leg. No.2 (24268	
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nd 2 should ealth and M n 27 is mai er traumat		19a. Informant's Na	me/Relationship			19b. Maili 106	ng Address (Street :	and Number or Run Drive 7	al Route Number, Annapoli	City or Towr	n, State, Zip 21409	o Code)	
t. Page 1 ar tment of He tant: If iter ijury or oth		4 Donation	☐ Cremation 3 5 ☐ Other (Spec		20b. Pla Ba [c Met]	ace of Dispo metery, creativin lodist	osition (Name of matory or other place In Ited Church (July Cemetery	^{Date} 16 2011				
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To the Hospital or Attending Physician: The law within 24 Hours after death. To the Funeral Director: After this certificate has I completed filled in by the funeral director, page 2 s	Certificate: 7	27. Manner of Death 1	5 ☐ Pending Investigati 6 ☐ Could not	28a. Date of inju (Month, Da	ury :	28b. Time o injury	f 28c. Injur work	y at	28d. Describe ho		Itizen of What Country? USA 14. Race - American Indian, Black, White, etc. Specify: White Kind of Business Industry Department of Town, State, Zip Code) MD 21409 Location - City or Town, State Ilersville, MD a Park Funeral Ho a Park, MD 21146 Approximate Interval Between Onset and Death Approximate Interval Between Onset and Death 2 No 3 Probably 4 Unkn 24b. Were autopsy findings availaberior to completion of cause death? No 1 Yes 2 No		
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Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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artme artme ortani injury		4 Donation 21. Signature of Fur				2.0	Al	rdent					8/2011		Jay Vear 16 2011 5:35 pM 4c. County of Death Howard Year 9. Birthplace (State or Foreign Country) PA 10d. Inside City Limits 1 Pes 2 No Og. Citizen of What Country? United States 14. Race - American Indian, Black, White, etc. Specify: White 16b. Kind of Business Industry Cwn Home Jaiden Surname) The Smith City or Town, State, Zip Code) Pendship, MD 21794 20c. Location - City or Town, State Hanover, MD Lizke's Family F.H.Ind Licott City, MD 21043 st, Approximate Interval Between Onset and Death Licott City, MD 21043 st, Approximate Interval Between Onset and Death Licott City, MD 21043 cacco use contribute to the cause of death? In Approximate Interval Between Onset and Death Licott City, MD 21043 Approximate Interval Between Onset and Death Licott City, MD 21043 Approximate Interval Between Onset and Death Licott City, MD 21043 Approximate Interval Between Onset and Death Licott City, MD 21043 Approximate Interval Between Onset and Death Licott City, MD 21043 Approximate Interval Between Onset and Death Licott City, MD 21043 Approximate Interval Between Onset and Death Licott City, MD 21043 Approximate Interval Between Onset and Death Licott City, MD 21043 Approximate Interval Between Onset and Death Licott City, MD 21043 Approximate Interval Between Onset and Death Licott City, MD 21043 Approximate Interval Between Onset and Death Licott City, MD 21043 Approximate Interval Between Onset and Death Licott City, MD 21043 Approximate Interval Between Onset and Death Licott City, MD 21043 Approximate Interval Between Onset and Death Licott City, MD 21043 Approximate Interval Between Onset and Death Licott City, MD 21043 Approximate Interval Between Onset and Death Licott City, MD 21043 Approximate Interval Between Onset and Death Licott City, MD 21043 Approximate Interval Between Onset and Death Licott City, MD 21043 Approximate Interval Between Onset and Death Licott City of Code Approximate Interval Between Onset and Death Licott City of Code Approxim			
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hat the ed by detacl	y Ph	Part II. Other signif		ons contr	ributing to d	eath but	t not res	ulting in the	underlying	cause giv	ven in Part	I.	23e. Did	tobacco	use contril	bute to t	he cause of de	ath?
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o the	Σ	only one) 3 29b. Signature and			Practioner:	lo the b	est of my		29	c. License	e number			29d. Da	ate signed	(Month.	Dav. Year)	
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10		30. Name and addre	ess of person	who com	npleted caus	se of dea		23a) (Type,	Print)	200	· C	مسا	usia	M	> 2	10	ty	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 11:15 PM REUBEN MITCHELL SR Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** DOCTORS HOSPITAL PRINCE GEORGE'S LANHAM 5. Social Security Number If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday, **Funeral** Months Days Hours Min. (Month, Day, SOUTH CAROLINA 1 X M 2 □ F **Director** SEPT. 248-42-5265 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location Director 1 X Yes 2 □ No MD PRINCE GEORGE'S MITCHELLVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1707 ALBERT DRIVE 20721 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Was Decedent Ever in U.S. Armed Forces?
1 IX Yes 2 □ No ARMY If Yes, Give Year or Dates. Black, White, etc. þ 1 Never Married 2 X Married 5-0036 BLACK 1 Tes 2 No Specify: 'natural", Completed 3 Divorced 4 Divorced Medical 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Meone. Baltimore, Maryland 2121 life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12TH CARETAKER PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ PAUL MITCHELL ELIZABETH LLOYD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NAZARENE MITCHELL/WIFE 1707 ALBERT DRIVE MITCHELLVILLE, MARYLAND 20721 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🛣 Burial 2 ☐ Cremation 3 ☐ Removal from State MD VETERANS CEMETERY 7/22/2011 CHELTENHAM, MARYLAND 4 Donation 5 Other (Specify) permit. 22. Name and Address of Facility J. B.JENKINS FUNERAL HOME, INC. 21. Signature of Funeral Service Licensee 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final RDIOP Ph_sician/ disease or condition resulting in death) Medical **Examiner** CONGESTIVE Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury ARDIO Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 2 🗌 No 9 Unknown s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by YPOTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of autopsy page death? 2 X No Yes 2 Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending injury nours after death. neral Director: Aft illed in by the fur Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral I

completed filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check 29b. Signature and title of cert 07-14-11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ELFAN 8118 Good LANHAM, MD ROAD

DHMH 17 Rev 7/2009

State Registrar

				Indelible Ink. Ensure All Copies	
		•	1 - State Registrar Co	partment of Health and Mental Hygertificate of Death	giene Reg. N2011 24271
ı	Physicia Medic		1. Decedent's Name (First, Middle, Last) Renee Sue Maxie-McKenzie	2. Date of Dea Month,	th Day Year 12:55 A M
	Examir		4a. Facility Name (if not institution, give street and number) Doctors Community Hospital	4b. City, Town, or Location of Death Lanham	4c. County of Death Prince George's
7	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda) 1 M 2 🔀 F 52 Yrs.	If Under 1 Year If Under 24 Hrs. 8. Date of Birt Months Days Hours Min. (Month 1991)	
	yland -f show ied at	Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or 1		10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	the Ma or 28a e notif	Dire	Maryland Prince George's Hyatts 10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	th with ns 23a must b	Funeral	4207 Longfellow Street	20781	USA
920	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show minjory or other traumatic event, the Medical Examiner must be notified at once.	ρ	11. Marital Status 1 □ Never Married 2 X Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ► No If Yes, Give Year or Dates.	3. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 Yes 2 Yes Specify:	14. Race - American Indian, Black, White, etc. Specify: White
21215-0036	72 hou n "natu Aedical	Completed	(Specify only highest grade completed) (Giv	sedent's Usual Occupation re kind of work done during most of working DO NOT use retired)	16b. Kind of Business Industry
212	within /giene.		I Flementary/Seconday (U-12) I College (1-4 or 5+) I	e & Attendance Clerk	Medical
Maryland	should be filed within and Mental Hygiene. is marked other tha raumatic event, the N	To Be	17. Father's Name (First, Middle, Last) William Maxie	18. Mother's Name (First, Middle, Janie Von	Lohr
	and 2 shoul Health and I tem 27 is m			illing Address (Street and Number or Rural Route Number 07 Longfellow Street Hyat	
nore	Page 1 ar ment of He ant: If iter ury or oth		1XX Duvid 2 □ Cromation 2 □ Removal from State Cemetery, Co	position (Name of Date ematory or other place) 1e Bap. Ch.Cem 7/16/2011	20c. Location - City or Town, State Upper Marlboro, MD
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signatus, of Funeral Service Jacense	22. Name and Address of Facility George P. 6160 Oxon Hill Road Oxon	
			23a. Part . Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.		rest, Approximate Interval Between
	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death) SEPTIC SHO Due to (or as a consequence of):		Onset and Death 2 WEEKS
	Examiner	ē	Sequentially list conditions, Due to lor as a consequence of:	ILURE	2 YEARS
	be executed sician and burial-transit	Examiner	If any, heating 1s immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	OLIC STEATOHEPATIT	15 5 YEARS
09	ate be ex hysician he burial	<u>@</u>	d		
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 4 ☐ Pregnant at time of death 3 9 ☐ Unknown	☐ Ectopic pregnancy ☐ Other (specify)	23d. Date of delivery Month Day Year
, P.O.	es that the	by Pi	Part II. Other significant conditions contributing to death but not resulting in the HEPATIC ENCEPHALOPATHY	e underlying cause given in Part I. 23e. Did to	obacco use contribute to the cause of death? Yes 2 M No 3 Probably 4 Unknown
ords	w requires to been so should	pletec	HEPATORENAL SYNDROME	24a. Was autoj	an 24b. Were autopsy findings available
I Rec	n: The la ficate ha or, page 2		25. Was case referred to medical	perfo 1 □ Yes	ormed death? 2 No 1 Yes 2 No
Vita	lysicial is certi directo	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpa	26. Place of Death (Check only one) ient 3 □ DOA Other: 4 □ Nursing Home 5 □ Resid	dence 6 Other (Specify)
n of	ding Ph th. After th funeral		27. Manner of Death 1 1 Natural 5 Pending 2 Accident Investigation 28a. Date of injury (Month, Day, Year) 28b. Time injury (Month, Day, Year)		now injury occurred
Division of Vital Records,	or Atten after deat Director:	Certificate:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)		Street and Number or Rural Route Number, vn, State)
	Hospita 24 hours Funeral	Medical	29a. Certifier (Check only one) 1 **Certifying Physician: To the best of my knowledge, dea only one) 3 **Certifying Physician: To the best of my knowledge, dea only one) Certifying Nyrse Practioner: To the best of my knowledge.	restigation, in my opinion, death occurred at the time, date a	and place, and due to the cause(s) and manner stated
	To the within To the compl	2	29b. Signature and title of certifier August 1: Mul. m	29c. License number D31345	29d. Date signed (Month, Day, Year)
	XX.		30. Name and address of person who completed cause of death (Item 23a) (Type	e, Print)	
	Sta		01 Date filed (Month Day Veer)	lville Rd. B340 Bowie, Ma	aryland 20716
	Registr	ar	MI 13 2011 Senera B.	back	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Amend#2perMD, #10aperFH; FCHD, Centificate of Death 7/26/11 KS Reg. N2 0 2. Date of Death 7/9/2011 July 8, Day 2011 Physician/ 11:12 A M William D. Marley Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Frederick Frederick Golden Living If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 6. Sex 1 ★ M 2 □ F Days Hours Min. Feb. 7, 1930 Maryland 81 Director 217-24-8108 Usual Residence of Decedent or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director X Yes 2 X No Catonsville Baltimore Maryland 10e. Stre 303 10f. Zip Code Street and Number 10g. Citizen of What Country? Maiden Choice Lane, Apt. 304 303 Maiden Court, Apt. 304 Funeral USA 21228 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14 Bace - American Indian 11. Marital Status Armed Forces?

1X Yes 2 \(\subseteq \text{No} \) 1948 Black, White, etc. ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced 1949 White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Telephone Company Lineman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Catherine Krieg David L. Marley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9004 Elkridge Lane, Frederick, MD 21701 19a. Informant's Name/Relationship (Type, Print) Krista Marley / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 7/13/2011 Frederick, Maryland Stauffer Crematory 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Funeral Home 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1621 Opossumtown Pike, Frederick, MD 21702 23a. P. Enter the dise set or complications that or use the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ATHENOSCLEMOSIC Physician/ ARTER OROWINY disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-transi Due to (or as a consequence of): attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 the for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Month per the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Vunknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ₩ No 24a. Was an has autopsy performe page 2 this certificate 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 - Residence 6 - Other (Specify) 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 7. Manner of Death 28c. Injury at work?
1 \(\subseteq \text{Yes} \) Certificate: 28b. Time of 28d. Describe how injury occurred After Natural Accident injury 5 \square Pending 2 No Investigation within 24 hours after deat To the Funeral Director: completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined

10 + IVA State

the

Registrar

Medical

29a. Certifier

(Check only one)

3 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

lm'

2011

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

127 = A KAZMI MN 814 TOIL HOUSE AVE, FREDERICK

32. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death popular, the time of the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

47951

29d. Date signed (Month, Day, Year,

-12-

2011

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend Item 21 per FH G918 8/3/11 dk
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. NoZ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2<u>011</u> Year Month **Physician** 3:00 aM Milton Joseph Michaelis July 16. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Kensington Nursing & Rehab. Kensington If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) June 26, 1928 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** Hours Months Days 1**X**XM 2□ F 83 D.C. 579-30-1067 Director Usual Residence of Decedent 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Examination ust be notified at 1 □Yes 2 No Director MD Montgomery Kensington 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 10814 Hobson Street 20895 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐Yes 2 🔼 No Specify. Š 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within intent of Health and Mental Hygiene. But: If Item 27 Is marked other than " College (1-4or 5+) Elementary/Secondary (0-12) Plumbing Contractor Plumbing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Siegfried Michaelis Aldona LaSalle ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Bessie Zenon Michaelis/Wife 10814 Hobson Street, Kensington, MD 20895 20c. Location - City or Town, State 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Department of Important: If It any injury or o July 18 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State Metropolitan Crematory Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 2011 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd. W,. Silver Spring, MD 20901 James E. Dooley per DVR 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between
Onset and Death
UNKNOWN Immediate Cause (Final Physician demen La disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Completed by Physician/Medical Examiner Due to (or as a consequence of) To the Hospital or Attending PhysIcian: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the aftending physician and completely lifled in by the funeral director, page 2 should be detached for use as the burlar-transit resulting in death) Last Due to (or as a consequence of) Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No o. 9 Unknown 9 Unknown ٣. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown wiluxe Were autopsy findings available prior to completion of cause of death? autopsy perform Hypothynia 1 ☐Yes 2 ☐No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation 1 ☐ Yes 2 No 2 ☐ Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Chrisdy 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DINO DRIVE, BURTONSVILLE, MD20866

DHMH 17 Rev 1/2001

State Registrar

104

M7;15216

egistrar's Signature

CHOWDHURY,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 24274 For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day}20<u>11</u> Physician/ July John Henry Patrick O'Grady 13 12:12 p^M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery General Hospital Olney Montgomery If Under 1 Year | If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Country 1 XM 2 Sept. 28, 1934 76 Director 115-26-6817 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13801 Blair Stone Lane 20906 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No
If Yes, Give Korean
Year or Dates.Confilct Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Siderographer Federal Government traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filk
Department of Health and Mental I
Important: If item 27 is marked of
any injury or other traumatic eve ည John O'Grady Mary Price 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Veronica O'Grady/Wife 13801 Blair Stone Lane, Silver Spring, MD 20906 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State July 18 4 Donation 5 Other (Specify) Gate of Heaven Cemetery Silver Spring, MD 2011 uneral Sirvice License Prancis J. Collins Funeral Home Inc 00 University Blvd. W., Silver Spring,MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ena disease or condition Medical resulting in death) Due to (or as a consequence of Examiner ravascular Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Iweek Hospital or Attending Physician: The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Fai VET that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify) _____ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 prior to completion of cause of death? certificate 2 No 1 Yes : After this certifical funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 Yes 2 No Accident Investigation within 24 hours after death

To the Funeral Director: A

completed filled in by the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) 0659 andwood 0 ter 23ar (Trpe, Print) 30. Name and address of person w/o complet of death ING,

DHMH 17 Rev 7/2009

State Registrar Toma

31. Date filed (Month

No

egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 26 per verb., g917.07/28/2011dhb

Certificate of Death

Reg. No. State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month July Physician/ Billy Gay Oakley 2011 5:40 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours January 8, 1922 445-34-9460 89 Oklahoma **Director** Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director Maryland Frederick Jefferson 1 🗌 Yes 2 🎦 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?

United States of America ō "natural", or items 23a o edical Examiner must be 21755 Funeral 4204 Wallingford Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify. 3 Midowed 4 ☐ Divorced White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Mea any injury or other traumatic event, the Mea ones, Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ William D. Clark Gaynell Teague 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Charles Oakley / Son 4204 Wallingford Court, Jefferson, Maryland 21755 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 A Cremation 3 Removal from State July 19, 2011 Smithsburg, Maryland Smithsburg Crematory 4 ☐ Donation 5 ☐ Other (Specify) Signature of Fune al service Ucense 22. Name and Address of Facility
Keeney & Basford P.A. Funeral Home
106 East Church Street, Frederick, Maryland 21701 M01433 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Subdural Immediate Cause (Final Physician/ hematoma disease or condition resulting in death) Medical Due to (or as a consequence of). Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

Within 24 hours after death.

The Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the invirsal director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of). Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month Year Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 🗌 No Yes 2 No 1 Yes Be B 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 X Yes Hospital: 2 🗌 No Other: မြ 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending Fall 7/13/2011 1 Yes 2 X No 2 Accident Investigation UNKNOWN 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 17204 Wellin Tout lace of Injury - At home, farm, street, factory, office 28e. determined building, etc. (Specify) Home Jetterson MD "Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier > mistl 7/16/11 MDH 67732

State Registrar St, Frederick

21701

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

400 W. 7th

Bruntel

Matthew By 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Items 24a and 25 per med cert G918 474 Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar 24276 Reg. No Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 12, 2011 11:31 A M Marsha Elizabeth Proctor Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death
Prince George's Examiner 4b. City, Town, or Location of Death Southern Maryland Hospital Clinton Social Security Number 8. Date of Birth (Month, Day, Year) Nov 18, 1949 6 Sex If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 M 2 T 214 58 1339 61 Washington DC Director Usual Residence of Decedent 28a-f show "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2XX No Prince George's Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9020 Darcy Road 20774Unite 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 ☐ Married þ ☐ Yes 2 🔀 No Yes, Give Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Completed 3 Divorced American Indian Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Disabled Elementary/Seconday (0-12) College (1-4 or 5+) Disabled Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Mildred Elizabeth Harley James Gwynne Proctor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chervl Garner (Sister) 13208 Water Fowl Way, Upper Marlboro, MD 20774 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2XX Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lee Crematory July16, 2011 Clinton, MD 21. Sign re of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria MO1555 Ferry Road, Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to for as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transi To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month Day Year signed by the a d be detached f Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has by page 2 s autopsy performed' death? Yes 2 X No 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 X No 은 1 Tes Other: 1 X Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at 28d. Describe how injury occurred 1 🗷 Natural 5 Pending work? within 24 hours after death.

To the Funeral Director: A: completed filled in by the fu 2 🗌 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Leading Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 24277 Reg. N Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month James R. Pennington, Sr. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Western MD Regional Medical Center Allegany Cumberland 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth

(Month, Day, Year)

Jan. 7, 1935 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Months Days 235-50-6273 76 Parsons, WV Director Usual Residence of Decedent 28a-f shov the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director WV Mineral 1 ☐ Yes 2X No Elk Garden 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a Rt. 1, Box 357 26717 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ò ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", 3 X Widowed 4 Divorced Specify: White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Operating Engineers Elementary/Seconday (0-12) College (1-4 or 5+) Heavy Equipment Operator Union Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F မ Doyle D. Pennington Hester G. Bonner permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James R. Pennington, Jr./Son Rt. 1, Box 96-A Elk Garden, WV 26717 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) .O.O.F. Cemetery Elk Garden, WV 21. Signature of Juneral Service Line 22. Name and Address of Facility Smith Funeral Home 85 S. Main Street Keyser, WV 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final nset and Death Acute Systolic and Directolic Heart Fachere Physician/ disease or condition ays Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami and -transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last g physician a s the burial-t Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No signed by the a Unknown g Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Acute and Chronic Rend Failure 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy Type 2 Disbeter Mellitus performe death? certificate 2 No Yes 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) 1 🗌 Yes 2 No Other: မ 1 Nnpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After this the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work? 1 🗌 Yes 2 🗌 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed only one 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatu D0018216

State Registrar Date filed (Month, Day, Year)

29 2011

12501 Willowbrook Rd Cambeland, MO 21502

and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	ell 1- For State Registrar	State of Maryl	and / Departm <i>Certific</i>			l Mental H		20 I	1 24278
Physician/ Medical Examiner	1. Decedent's Name (First, Marshall	Louis Rus	ssell_				2. Date of Deat Month July 19, 20	h Dav Year	3. Time of Death 2235 hrs
	4a. Facility Name (if not inst St. Mary's Hospita	titution, give street and n	umber)	41	c. City, Town, or L Leonardtowr	1		4c. County of D St. Mary's	
Funeral Director	5. Social Security Number 220-78-1519	6. Sex 1 X M 2 F	7. Age (In yrs. last bir 50	thday) Yrs.	If Under 1 Year Months Days	If Under 24Hrs Hours Mir	_	Fo	. Birthplace (State or oreign Country) Maryland
nd sbow acy See.	Usual Residence of Decede 10a. State 10b. Co Maryland St.	unty	10c. City, Town		n				10d. Inside City Limits 1 Yes 2 X No
rith the Maryland 123a or 28a-f show 1 notified at occe. 1 al Director	10e. Street and Number 45758 Chance	ellors Mill	Lane		10f. Zip Code		U	og. Citizen of What on ited Sta	tes
or items must be	11. Marital Status 1 Never Married 2 3 Widowed 4	_ 4 15	2 No	If Ye	Decedent of Hisps, specify Cuban, Yes $2X$ No	Mexican, Puerto	pecify Yes or No- o Rican, etc.)	White, et	merican Indian, Black, ic. Black
5-0036 ed within 72 hours : tygiene. other thao "oaturn the Medical Exami Completed b	15. Decedent's Education Elementary/Secondary (0	(Specify only highest gra	(1-4 or 5+)	during mo	s Usual Occupations of working life.	DO NOT use ret		16b. Kind of Busine	
21215-0036 und be filed within 7 Mental Hygiene. marked other thao e evect, the Media	17. Father's Name (First, Mi Bennie Louis 19a. Informant's Name/Rela	Russell			1,	8.Mother's Name Vivian I	nez Rot	faiden Surname)	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "oatural", injury or other traumatte evect, the Medical Examiner To Be Completed by I	Vivian I. Wa 20a. Method of Disposition 1 X Burial 2 Crem 4 Donation 5 Other	nation 3 Removal f	20b. Place cremate	5758 of Disposit tory or othe	Chance1 ion (Name of cemer place)	lors Mil	1 Lane. Date	Great Mi 20c. Location - City	11s MD 20634 y or Town, State
Physician	21 minates of Funeral Se Edward N. Bri 23a. Part I. Enter the diseas failure. List only one c	nsfield, James, or complications that	. M00052	22. Na	emorial (ime and Address of Bondard () 55 Holls of dying, s	of Facility Bri wwood_Ro	nsfield	nardtown.	Home, P.A.
/Medical Examiner	Immediate Cause (Final dis or condition resulting in dea	ease a. Pulmo	onary thron a consequence of):	nboeml	oolism				Death
uted d ansit Examiner	if any, leading to immediate cause. Enter Underlying Ca (Disease or injury that initial events resulting in death) L	ause c	a consequence of):						
60, e be executed ysician and burial - transi			27, per ME g	g923 I	1/27/12	TRT		Look Bata at the	
P.O. Box 68760, that the death certificate be executed red by the attending physician and detached for use as the burial - transit by Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant past 12 months? 1 Yes 2 No 9	t in the 1 Live	birth nant at time of death		I death 3 ar (Specify)	Ectopic pregna	ancy	23d. Date of deli Month	very Day Year
ds, P.O. quires that the sen signed by t uld be detache ted by Pl	Part II. Other significant co	onditions contributing t	o death but not resultin	g in the un	derlying cause gi	ven in Part I.		2 No 3 1	e to the cause of death? Probably 4 Unknown a autopsy findings available
tal Records, leian: The law requires certificate has been signector, page 2 should be Be Completed	25. Was case referred to me	edical			26 Place o	of Death (Check	autops perform 1 V Yes 2	sy prior med? death	to completion of cause of h?
I of Villing Physical Head of The His funeral dir.	examiner? 1 Yes 2 No 27. Manner of Death 1 X Natural 5	Hospital: 1	Inpatient 2 ER/O e of Injury h, Day, Year)	utpatient Time of Inj	3 DOA Cury 28c. Injury	ther -	ng Home 5 .	Residence 6 O	ther:
Division C Hospital or Atteodiog 44 hours after death. Fluorral Director: Af Fluorral Director: Af Fluorral Director or Af an Certification	3 Suicide 6 4 Homicide		ce of Injury - At home, fa	arm, street,	factory, office bu	ilding, etc.	28f. Location (S or Town, St		Rural Route Number, City
2 7 2 7 6	one) 2 Medical	ng Physician: To the be Examiner: On the basis and manner:	of examination and/or i		n, in my opinion,	death occurred a		and place, and due to	o the cause(s)
	29b. Signature and title of co	ethall, MD	as at death (Herr 22a)		29c. License O.C.M			29d. Date signed (Month, Day,Year)
Since	30. Name and address of pe Pamela E. Southa 31. Date filed (Month, Day,	II, MD Assistant	Medical Examine	_		Street, Balti	more, MD 21	223	
State Registrar	JUL 2	6 2011	we B.	par	41				
DHMH 17 Rev 1/2001			OR	RIGINAL			DOME		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month July 16 Physician/ Rosamond S. Ridgley Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5642 Chelwynd Road Halthorpe 5. Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth Funeral 1 M 2 XF Months Davs Hours Min. 10/23/194 69 Director 220-38-6638 Usual Residence of Decedent 28a-f show 10a, State 10c. City, Town or Location Examiner must be notified at Director MD Baltimore Halthorpe 10e. Street and Number 10f. Zip Code 5 10g. Citizen of What Country? Funeral items 23a 5642 Chelwynd Road 21227 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian and 2 should be filed within 72 hours after d Health and Mental Hygiene. tem 27 is marked other than "natural", or i 2 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Completed 3 XWidowed 4 ☐ Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours Inepartment of Health and Mental Hygene. Inportant: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Registered Nurse Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Wesley Joseph Sturm Mildred Forman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5642 Chelwynd Road Halthorpe, MD Linda Leppert - sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07/21/2011 Marriottsville, MD Crest Lawn Mem. 21. Signature of Funeral Service Licensee ^{22. Name and Address of Facility} Harry H. Witzke's Family F.H.Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ po JAn Cor disease or condition / Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events physician and s the burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 d guipt lse as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Pregnant at time of death signed by the a 1 Yes 2 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an Jas autopsy performed? Yes 2 certificate 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) 2 KNO Other: ဂ္ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 Presidence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural Accident injury work? 1 ☐ Yes 2 ☐ No 5 Pending hours after death. neral Director: Aff d filled in by the fur Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and tif

24279

7:00

9. Birthplace (State or Foreign

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 ☐ Yes 2 🔀 No

2011

Baltimore

Black, White, etc.

Month

MO

Day

Yes

Year

White

Country)

lp

State Registrar

DHMH 17 Rev 7/2009

tomun2

Red: U

completed cause of death (Item 23a) (Type, Print)

405

egistrar's Signature

KACZU 4

1/14/110 03/40 Roark, Barbara Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		Please Type or Print in						egible.	
	-	State of Maryla		rtment of F tificate of L		lental Hy	giene Reg. No.2	011	21,280
D		Registrar 1. Decedent's Name (First, Middle, Last)				2. Date of De	ath	Voor	3. Time of Death
Physicia Medic	al	Barbara Carol Roark				July 1		011 ^{Year}	9:46 am
Examin		4a. Facility Name (if not institution, give street and number) Shady Grove Adventist Hospital	- 1	Ab. City, Town, or Rockvill	Location of Death			ontgom	
Funeral Director		5. Social Security Number 022-34-1166 6. Sex 1	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Feb. 9	th y, Year) 1947	g. Birth Cour	place (State or Foreign ntry) NH
-f show ed at	ctor	Usual Residence of Decedent	City, Town or Loca						10d. Inside City Limits 1 ☐ Yes 24☐ No
he Ma or 28a notif	Funeral Director	10e. Street and Number		10f. Zip Code			10g. Citizen	of What Cou	
s 23a uust be	eral	19240 Treadway Road		208	33		USA		
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 ☐ Never Married 2 ⚠ Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.	lf.		ispanic Origin? (Spe in, Mexican, Puerto Specify:		E	Race - Americ Black, White, cify: Whi	etc.
hin 72 hour ne. than "natu ie Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)	(Give ki. life. DO	NOT use retired)	during most of worki	ing		of Business In	dustry
e filed with	To Be C	12 17. Father's Name (First, Middle, Last) John Martin Owens	Sto	re Manag	18. Mother's Name	e (First, Middle, Mary Fu	Maiden Surna		
2 should be th and Mer 7 is mark traumatic		19a. Informant's Name/Relationship (Type, Print) James A. Roark/Husband			and Number or Rura	al Route Numbe	r, City or Tow		
ge 1 and 2 nt of Healt t: If item 2 or other		20a. Method of Disposition 1 KPsurial 2 Cremation 3 Removal from State	o. Place of Dispos cemetery, crema	ition (Name of atory or other plac	se) Ju	Date	20c. Location	on - City or To	own, State
permit. Pa Departme Importani any injury once.		4 Donation 5 Other (Specify) St 21. Signature of Funeral Service Licensee	. Patric		ctery	2011		Inc.	MA 20901
		23a. Part 1. After the disease, or complications that caused the deshock, of heart failure. List only one cause on each line.			g, such as cardiac o	or respiratory ar		3772.8	Approximate Interval Between Onset and Death
Physician/ Medical Examiner		disease or condition resulting in death) a. Due to (or as a conse		char	e le	est			
e executed clan and urial-transit	al Examiner	Sequentially list conditions, if any, reading to immediate Due to (or as a const	omyop						
icate b	ledic	d							
Physician: The law requires that the death certificate be ex- this certificate has been signed by the attending physician ral director, page 2 should be detached for use as the burial	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 1% months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of preg 1 ☐ Live Birth 2 ☐ F 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3 🗌	Ectopic pregnand Other (specify)	су		23d.	Date of deliv Month	very Day Year
r requires that the de been signed by the should be detached		Part II. Other significant conditions contributing to death but not End Starl renal d	resulting in the un		ven in Part I.				the cause of death?
require been s should	leted	morbid obesity	13EU36			24a. Was			opsy findings available
The law ate has page 2	Completed by	TROTOTA GUESTA				auto perfo 1 \(\sum \text{Yes}	psy	prior to co death? 1 \square Yes	ompletion of cause of
ician: certific ector,	Be	25. Was case referred to medical examiner? Hospital:		Oth	ace of Death (Check	k only one)			
g Phys er this neral dir	te: To	27. Manner of Death 28a. Date of injury	ER/Outpatient 28b. Time of Injury	28c. Injur	4 □ Nursing Ho y at	ome 5 Resi 28d. Describe I			y)
ttendin death. :tor: Aft r the fur	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be			Yes 2 No	20f Loantion A	Ptmat and Nu	mhar ar Russ	al Route Number,
tal or A rs after al Direc ed in by	al Cer	4 Homicide determined 28e. Place of Injury - Albuilding, etc. (Spec		et, factory, office	h,	City or Tov		mider or Hura	ii noute Number,
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 v.	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my kni (Check only one) 3 Certifying Nurse Practioner: To the best of	ation and/or investig	gation, in my opinio	on, death occurred a	t the time, date :	and place, and	due to the ca	ause(s) and manner stated
To the within to the company of the		29b. Signature and the of certifier		29c. Licenso	e number -9/1/8		29d. Date sig	ned (Month)	Day, Year)
12		30. Name and address of person who completed cause of death (III	tem 23a) (Type, Pr			ika	Rock	ville.	MD 20850
Stat Registra	e ar	31. Date filed (Month, Sur Year) 8 2011 32. Rigistrar's Sig	nature A.	ares					

Amend #19aper									_		
AACO Health Dep	1	_ State	arylan	-	artment of t tificate of t		Mental Hy	/gien	0011	24282	
		1. Decedent's Name (First, Middle, Last) 2. Date of						eath		3. Time of Death	
Physician/ Medical		Mary Russo		July 9, 2011 Year 3:45P M							
Examiner	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death										
Funeral		Crofton Convalescent Cent Social Security Number 6. Sex 17. Age		st birthday)	Crofto	n If Under 24 Hrs		rth	Anne Ar	undel thplace (State or Foreign	
Director		570-42-0201 1 M 2 VIE				(Month Day Year) Cr			untry) necticut		
land show dat	- 1-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Lin									
Maryla Ba-f s stiffed		Maryland Prince George	Ft.	Washi	ngton					1 ☐ Yes 2 🏋 No	
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mentall Hygiene. Important: If time 27 is an arked other than "natural", or items 23a or 28a-1 sho any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director		0e. Street and Number 307 Foundry Lane		10f. Zip Code 20	744			Citizen of What Co	ountry?		
death \ items items ier mu		1. Marital Status 12. Was Decedent E	ver in U.S	. 13. V	Vas Decedent of H	lispanic Origin? (S an, Mexican, Puerl	pecify Yes or No-		14. Race - Ame		
after c		1 ☐ Never Married 2 ☐ Married 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ⚠ No If Yes, Give Year or Dates			1 ☐ Yes 2 🛣 No Specify:				Black, White Specify: Wh:		
5-00 hours nature lical E	+	15. Decedent's Education		16a. Deced	lent's Usual Occup	pation		16b.	Kind of Business		
1215-003 rithin 72 hours ar ene. r than "natural" the Medical Ex	ŀ	(Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5	+)	life. DO	O NOT use retired)	during most of wo	rking	Ι.			
d 2. led wit Hygie other ent, the		7. Father's Name (First, Middle, Last)		Homen	naker	18 Mother's Na	me (First, Middle,		Wn Home		
Ilan I be fil Inked a ric ev		Anthony Zappulla				Antoin	eo				
Maryland 21215-0036 2 should be filed within 72 hours after thit and Mental Hygiens 27 is marked other than "natural", o traumatic event, the Medical Exam To Be Completed by		19a. Informant's Name/Relationship (Type, Print)				and Number or Ru				'	
e, N and 2 Health em 27	ŀ	Angela J. Maris/Daughter On Method of Disposition	Look B			ane, Ft.					
Baltimore, bernit. Page 1 and beginnent of and mportant: if then my injury or other	ľ	1 ☐ Burial 2 ☐ Cremation 3 🛣 Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	St.	ace of Dispos metery, crem Josep	sition <i>(Name of</i> natory or other place h's Ceme	tery 7/2	Date 1/2011	ı	Location - City or erbury ,	· ·	
calti	ŀ	21. Signatur, or Funeral Sergice Licensee 22. Name and Address of Facility George P. Kalas Funeral Home									
	1	6160 Oxon Hill Road, Oxon Hill, Md. 20745									
124 544		23a: Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition for the condition									
Pnysician/ Medical	П	disease or condition resulting in death) a. Due to (or as a				•	/ :			6 MONTAS	
Examiner		Sequentially list conditions.	2 h		ner	Deme	ntia			5 years	
xecuted and all-transit	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or iinjury										
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687 ertifica ertifica bing place as t	-	F FEMALE: 23c. If yes, outcome of	of pregnar	ncv							
OO CO CO CO CO CO CO CO CO CO CO CO CO C								23d. Date of delivery Month Day Year			
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S, P. res tha signed at be de	۱'	Part II. Other significant conditions contributing to death bu	it not resu	liting in the ui	nderiying cause gi	ven in Part I.	23e. Did t			the cause of death?	
Sponous Penal 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1							24b. Were autopsy findings available				
The law reduiries and the law spean size and							prior to	prior to completion of cause of death? 1 ☐ Yes 2 ☐ No			
tal Figure 1 cian: Tetrifica ector, p		5. Was case referred to medical examiner?				ace of Death (Che		4/4 1	101 1 100	2 110	
f Vi Physic this c ral dire		1 ☐ Yes 2 No Hospital: 1 ☐ Inpatie 7. Manner of Death 28a. Date of injur		ER/Outpatien 28b. Time of		4 Nursing I			6 Other (Spec	ify)	
on on on on on on on on on on on on on o		28a. Date of injury 1							ry occurred		
The state of the s								mber or Rural Route Number,			
29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as									itad		
he Hospita in 24 hours he Funeral pleted filled		(Check only one) (Certifying Physician: To the best of	amination	and/or invest	igation, in my opinie	on, death occurred	at the time, date a	and plac	e, and due to the	cause(s) and manner stated.	
To the within To the committee of the the committee of the the committee of the the the the the the the the the the		9b. Signature applittle of contifier	n	10	29c. Licens	0295	71	29d. Da	ate signed (Ment)	n, Day, Year)	
Thy I	3	0. Name and address of person who completed sause of de	ath (Item	23a) (Ilvne P			. ,	0/	11/4	///	
22		Paul Berez MD 2	225		refe.	158 t	try,	C	rofto	n, MD21114	
State Registrar	3	1. Date filed (Month, Day, Year) JUL 13 2011 32. Registra	r's Signati	A. A	arked						

State of Maryland / Department of Health and Mental Hygiene Trinace Richardson 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month 1935 hrs July 8, 2011 RICHARDSON Medical Examiner С. TRANICE 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Frederick Frederick Orchard Terrace & Hill Street If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or Foreign NEW 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. Country) YORK Director NOV. 16,1977 219-15-3718 Yrs 1 M 2 X F 33 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 1 X Yes 2 No Maryland Frederick Frederick 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Director 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21702 1155 Orchard Terrace 14. Race - American Indian, Black, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 12. Was Decedent Ever in U.S. 11. Marital Status White, etc. Armed Forces 1 X Never Married 2 Married Yes Specify: Black 1 Yes 2 X No specify: 4 Divorced if Yes, Give Year 2 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) the Medical none 21215-0036 10 none 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Ann Powe11 Be Cedric J. Richardson If item 27 is marked 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 19a. Informant's Name/Relationship (Type, Print) QM Cedric J.Richardson/Father 1416 Hunting Horn La./ Frederick, MD 21702 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a. Method of Disposition timore. crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 07/16/2011 Frederick, Maryland Fairview Cemetery 4 Donation 5 Other Specify 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 24. ign ture of Funeral Service Licenses 1621 Opossumtown Pike/Frederick, MD 21702 iseas or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and Fire. List only one cause on each line. Death /Medical a. Multiple Gunshot Wounds Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Hospital or Attending Physician: The law requires that the death certificate be executed sician/Medical **AMENDED** signed by the attending physician be detached for use as the burial -UNPENDED Box 68760. 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Day 1 Live birth Fetal death 2 past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 ✔ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.0. 1 Yes 2 No 3 Probably 4 Unknown ğ Completed 24b. Were autopsy findings available Records, certificate has been sector, page 2 should 24a. Was an prior to completion of cause of autopsy death? performed Yes 2 No 1 🗸 Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical director, of Vital Be Other Nursing Home 5 Residence 6 Other: Scene examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA After this ✓ Yes 2 No 28a. Date of Injury Jul 8, 2011 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 27. Manner of Death Certification: Subject shot 0000 hrs Natural 1 Yes 2 ✔ No Division 5 Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be or Town, State) Orchard Terrace & Hill Street, Frederick, MD Suicide determined (Specify) Local Street 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Windical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie July 9, 2011 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Carol Allan, MD 31. Date filed (Month) 32. Registrar's Signature acke State Encua Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

11-05105

			State of Maryland /	Department of Health and N		ene						
			State Registrar 1. Decedent's Name (First, Middle, Last)	Certificate of Death		2011 24284						
	Physicia Medic		Gilbert Stepney	2. Date of Death								
	Examin	er	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death Harford						
37~~	Funeral		Harford Memorial Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last bit	Havre de Grace rthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y	9. Birthplace (State or Foreign						
	Director		207-14-7825	Yrs. Months Bays Floors Will.	11/28/1							
	yland -f shov ed at	Funeral Director	10a. State 10b. County 10c. City, Tov MD Kent Worte	vn or Location		10d. Inside City Limits 1 □ Yes 2 □ No						
	the Mar or 28a e notifi		10e. Street and Number	10f. Zip Code	10	g. Citizen of What Country?						
	th with ns 23a must b	nera	24970 Lambs Meadow Road	21678		USA 14. Race - American Indian,						
9	or iter		11. Marital Status 1. ★ Marital Status 1. ★ Never Married 2		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)							
-003	ours af atural", cal Exa	Completed by	3 Widowed 4 Divorced If Yes, Give Year or Dates. 15. Decedent's Education 16	a. Decedent's Usual Occupation	1 Yes 2 No Specify:							
215	iin 72 h ie. han "n e Medi	dmo	(Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)	(Give kind of work done during most of work life. DO NOT use retired)	ing	6b. Kind of Business Industry						
d 21	led with Hygier other t ent, the	To Be C	unknown 17. Father's Name (First, Middle, Last)	Laborer 18. Mother's Nam	ne (First, Middle, Ma	Unknown iden Surname)						
ylan	ld be fi Mental Iarked atic ev		Unknown	Unkno	own							
Z Z Mar	2 shouth and 27 is rr			9b. Mailing Address (Street and Number or Run 24970 Lambs Meadow								
\mathcal{OROPAM} Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemet	of Disposition (Name of ery, crematory or other place) 7 / 1	Date 2	0c. Location - City or Town, State Dover, DE						
80 Iltim	nit. Pag artmen ortant: injury		4 Donation 5 Other (Specify) 21. Signeture of Funeral Service Licensee	22 Name and Address of Eacility								
Ø ₩	perr Dep Imp any any		Bennie Smith Funeral Hom									
	Philipp Parkers II		23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Immediate Cause (Final			t, Approximate Interval Between Onset and Death						
-	Physician Medical Examiner		disease or condition resulting in death) a. Due to (or as a consequence)	ASTO ENTESTINAL 1	breed							
/13/1	Lxammer	Jer	Sequentially list conditions, if any, leading to fininediate	J Cfr.								
1	be executed iician and burial-transit	cal Examiner	Cause. Enter Underlying Cause (Disease or iinjury that initiated events c.									
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PNE)	rtificate ling phy e as the	/Med	IF FEMALE:									
Tep. Box 6	Second September 1 1 1 1 1 1 1 1 1 1											
57.0	at the d d by the etached	23e Did toba	obacco use contribute to the cause of death?									
S, P	uires thi n signe	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of the ca										
Records,	law req nas bee e 2 shou	nplet			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of death?						
Ser.	in: The ificate h or, page		25. Was case referred to medical	26. Place of Death (Chec	1 Yes 2							
<i>G, //</i> of Vital	hysicia his cert il direct	To Be	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)									
(1) P	27. Manner of Death 28a. Date of injury 28b. Time of injury 28c. Injury at work? 1 Natural 5 Pending 2 Accident Investigation 28b. Time of injury 4 work? 1 Yes 2 No											
Division	or Atter fter dea irector n by the	Certificate:	3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
ā	To the Hospital or Attending Physician: The law requires that the death certificate I within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completed filled in by the funeral director, page 2 should be detached for use as the	Medical C										
	thin 24 the Fu	Med	(Check only one) (Check one) (Check one)									
	5 × 5 0		Varished Sweed M1) D0065966 7/13/11									
	+ ~~		30. Name and address of person who completed cause of death (Item 23a	ON Ave Havre de	GOACO	MD 21078						
	ເກາ≲ Sta	te	31. Date filed (Month, Day, Year) 32. Redistrar's Signature	has he de	CRICE	1110 00/010						
	Registr	ar	JUL 1 5 2011 Brown	11								

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State of Maryland / Department of Health and Mental Hygiene.

	•	For State Registrar	State of Ma	ai yilai i		ficate of	Death		Reg. No.	011	24285	
Physicia		1. Decedent's Name (First, Middle, La Alice	,	ultz				2. Date of Dea)11 Year	3. Time of Death 10:13P M	
Medic Examin					2	4b. City, Town, or Location of Death Clinton 4c. County of Death Prince George						
Funeral Director		Social Security Number 6.		(In yrs. I		If Under 1 Year Months Days	If Under 24 Hrs	8. Date of Birt	h Voorl	9. Birt	hplace (State or Foreign intry) ISV1vania	
yland f show ed at	ctor	Usual Residence of Decedent										
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertall Hyglene. Important: If time ZT is marked other than "natural", or items Z3a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	al Director	10e. Street and Number 5404 Temple Hill	bre utr	10f. Zip Code 20748				10g. Citizen of What Country?				
	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent E Armed Forces?	If Y	13. Was Decedent of Hispanic Origin? (Specify Yes or Nolif Yes, specify Cuban, Mexican, Puerto Rican, etc.)					rican Indian, o, etc.		
	Completed	3 Widowed 4 □ Divorced 15. Decedent's (Specify only highest g Elementary/Seconday (0-12)	Year or Dates. Education	+)	16a. Deceder	nt's Usual Occu d of work done NOT use retired	pation	rking	16b. Kin	nd of Business I		
	To Be C	17. Father's Name (First, Middle, Last, Andrew Nypav	;)		Tromemar		18. Mother's Na	me (First, Middle, Novotny	Maiden S	Home urname)		
		19a. Informant's Name/Relationship (Raymond J. Schul					t and Number or Ru 11e Meado	ıral Route Numbei	; City or T		Code) VA 22066	
		20a. Method of Disposition 1 🕅 Burial 2 🗆 Cremation 3 1 4 🗆 Donation 5 🗀 Other (Spec	☐ Removal from State		Place of Disposit	ion (Name of	acel	Date	20c. Loc	cation - City or	Town, State	
permit. I Departn Importa any inju		Arlington Nat'l Cem 8/24/2011 Arlington, VA 21. Signature of Funeral Service Licensee Arlington Nat'l Cem 8/24/2011 Arlington, VA 22. Name and Address of Facility George P. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill, MD 20745										
Physician/		23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one dause on each line. Immediate Cause (Final disease or condition And Human Cause (Final disease or condition)										
Medical Examiner transit	J.	Due to (or as a consequence of):										
	Aedical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):										
ificate be executed g physician and as the burial-transit	edical		d .									
ss that the death certific igned by the attending be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live Birth 1 ☐ Pregnant at g ☐ Unknown	2 🗌 Feta	al death 3 🔲 🛭	Ectopic pregnal Other (specify)	ncy		2	3d. Date of deli Month	ivery Day Year	
	by	Part II. Other significant conditions contributing to death out not resulting in the underlying cause given in Part I.										
law nas e 2 s	Completed	24a. Was an autopsy performed? 1 ☐ Yes 2 ▼ No 1 ☐ Yes										
Physiclan: The this certificate I ral director, page	Be	25. Was case referred to medical examiner?	Hospital:			Ot	Place of Death (Che	ck only one)				
Phy this ald	e: To	1 ∐ Yes 2 X No 27. Manner of Death	1 Inpatie	у	ER/Outpatient 28b. Time of	3 DOA 28c. Inju	4 ∐ Nursing I	lome 5 Resid			(fy)	
Attending or death. ector: After by the fune	Certificate:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not	be 280 Place of Inju		injury ome, farm, street	M 1 [rk? ☐ Yes 2 ☐ No	28f. Location (Street and Number or Rural Route Number,				
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral		4 ☐ Homicide determined	building, etc	building, etc. (Specify)				City or Tow	City or Town, State)			
To the Hos within 24 h To the Fun completed	Medical	(Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner sonly one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
× × × × × × × × × × × × × × × × × × ×		29b. Signature and title of certifier	rel 6-		8	D5	\$209		7	signed (Month	avay, rearj	
4,8		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wandall Planson 7503 Surratts Rd. Clinton Md 20735										
Stat		31. Date filed (Month, Day, Year)	32. R/gistra	r's Signa	ture A	uks		7				

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Amend#7 per FD Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AACO Health Dept. 7-15-11 KAH State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 24286 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month July Physician/ James D. Sleeman 9 :45 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Anne Arundel Annapolis 5. Social Security Number Age (In vrs last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Hours Oklahoma 218-38-6982 70 69 Yrs Director Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Annapolis 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 125 Chester Avenue 21403 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛱 No Specify: If Yes, Give Year or Dates. 1962–86 Completed 3 Divorced 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Senior Audio Engineer USAF/VOA Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Charles Herbert Sleeman Mary Margaret Daugherty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sally S. Lambe/ Sister 4834 Chevy Chase Blvd., Chevy Chase, MD 20815 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place, Kalas Crematory Edgewater, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 7/13/11 21. Signat 19/10 al Se ce Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ -mphyseina Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of): nding physician a Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Year Day Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗌 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 📉 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 XInpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 124 hours after death. ☐ Accident 1 Tyes 2 🗌 No Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 1 Xcertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year)

CH9H State

Registrar

31. Date filed (Month, Day, Year)

1

30. Name and address, of person who completed cause of death (Item 23a) (Type, Print) Parhway, and puts, Mos John Michael Parhway, and puts, Mos

32. Registrar's Signature

D46052

7/9/11

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Snyder Virginia Dare 2011 12:35 P M Julv 10. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Anne Arundel Annapolis Anne Arundel Medical Center 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 8. Date of Birth Social Security Number **Funeral** 1 □ M 2 💢 F Hours 94 173-14-4531 Maryland Director 1917 <u>June</u> Usual Residence of Decedent 28a-f shov iral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director Severna Park MD Anne Arundel 1 Yes 2 X No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 21146 715 Benfield Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: ed other than "natural", event, the Medical Exar Specify: 3 ▼ Widowed 4 □ Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Home 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mary Haney Thomas Comer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7402 Kent Point Road Stevensville, MD 21666 Norman Snyder / Son 20a. Method of Disposition 20b. Place of Disposition or other place. Glen Haven Memorial Park 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State July 13 Glen Burnie, MD 4 Donation 5 Other (Specify) 21. Signature of 22. Name and Address of Facility Barranco & Sons, 495 Ritchie Hwy, P.A. Severna Park Funeral Home Severna Park, MD 21146 Severna Park, 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fig. Immediate Cause (Final Onset and Death Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to or as a consequence of) cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗌 No Yes Hospital or Attending Physician: 24 hours after death.

Funeral Director: After this certific filled in by the funeral director, 25. Was case referred to medical å 26. Place of Death (Check only one) examiner? Hospital မ 1 🗌 Yes 2 No 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending work? 2 🔲 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29b. Signature and title of 29c. License number 29d. Date signed (Month, Dav. Year) who completed cause of death (Item 23a) (Type, Pr

Registrar DHMH 17 Rev 7/2009

State

30. Name and address of pe

1 4 2011

31. Date filed (Month.

egistrar's Signature

For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Seibert Elizabeth Emma 08 July Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Pasadena Peartree House Assisted Living If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Social Security Number Age (In yrs. last birthday) 8. Date of Birth **Funeral** April 02, 1922 1 □ M 2 💢 F 89 Months 217-16-0220 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland Director MD Anne Arundel Arnold 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21012 USA 475 Louise Lane 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 🔯 No Specify: Specify: 3 Widowed 4 Divorced j 2 should be filed within 72 hours a alth and Mental Hygiene. I 27 is marked other than "natural or traumatic event, the Medical E) Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Banking Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Bridget Delores Conaway John Frederick Dittmar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 160 Shields Lane Queenstown, MD 21658 Kathleen McCann / Attorney Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State July 11, 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Baltimore, MD Metro Crematory, INC. 2011 Signature of Funeral Service Licensee Barranco & Sons, P.A. 495 Ritchie Hwy, Severna Park Funeral Home Severna Park, MD 21146 Ritchie Hwy 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ULON Physician/ Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physician Physician/Medical Box 68760 the for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Yes 2 No 1 Yes 2 L 9 Unknown ed by the a g Unknown P.O. signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed Yes 2 page within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 No ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural 5 Pending Division 1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiener

24288

3. Time of Death

g. Birthplace (State or Foreign

10d. Inside City Limits

Approximate Interval Between Onset and Death

Year

Day

death? 1 Yes 2 No

3 Probably 4 Unknown

1 Yes 2 X No

Maryland

White

2011

9:00

32. Revistrar's Signature State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dabbs.

DHMH 17 Rev 7/2009

ORIGINAL

277 Reninsula Farm Rd Amold MO 21012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician/ : 00 A-M . Medical a. Eacility Name (if not institution, give street and number, or Location of Death County of Death Examiner end 8. Date of Birth 9. Birthplace (State or Foreign . Age (In vrs. last birthday) **Funeral** Country) Maryland 1**X** M 2 □ F Months Davs Hours Min (Month, Day, Year) 09-11-1919 Director 214-18-8919 91 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits with the Maryland ms 23a or 28a-f shor must be notified at 10c. City, Town or Location Director 1 Yes 2 No Prince George's Bradywine MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20613 USA 14402 Baden Naylor Road items ? and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status or other traumatic event, the Medical Examiner Armed Forces? Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates. 1944–46 "natural" 3 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry than Elementary/Seconday (0-12) 5th College (1-4 or 5+) Agriculture Farmer and Mental Hygier is marked other i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Edward Sanner Sarah C. Biscoe 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 14402 Baden Naylor Road, Bradywine, MD 20613 Priscilla A. Sanner/Spouse 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date Department of H Important: If ite any injury or otl cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Maryland Veterans Cemi. 07/15/2011 Cheltenham, Maryland of Funding S Beall Funeral Home Bowie, MD 20715 6512 NW Crain Hwy., 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sician/ Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Examine Due to (or as a consequence of): attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending naturalists. P.O. Box 68760 IF FEMALE s, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Fetopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) Pregnant at time of death been signed by the a should be detached f Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has funeral director, page 2: autopsy performe Yes 2 K Be 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one, examiner? 1 ☐ Yes 2 🐪 Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 5 Pending Accident Investigation 6 🗌 3 ☐ Suicide 4 ☐ Homicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🔀 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature 29d. Date signed (Month, Day, Year) Name and address of pers dea

Registrar
DHMH 17 Rev 7/2009

State

egistrar's Signature

1 4 2014

Eldezburg

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. For State Registrar 24290 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Year Month -13 1650 Frank Winter Siehler, Jr. 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner None Union Memorial Hospital Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 07/21/1938 72 Yrs MID **Director** 213-36-6314 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b, County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Yes 2 □ No MD None Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? must be r Funeral United States 1322 Dellwood Avenue 21211 items 2 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status "natural", or ite Armed Forces? Black, White, etc. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 😾 No Specify: 3 Divorced 4 Divorced White Completed the Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 73 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Technician/Product Supplier Vending Machine Co. 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Frank Winter Siehler, Sr. Helen Veronica O'Connor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan Barbara Duckworth - sis. 125 Lagoon Drive Gulf Shores, AL Department of Health Important: If item 27 any injury or other the once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State Ardent Crematory 07/18/2011 Hanover, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ Res Distress Sindrame oratory disease or condition Medical resulting in death) Due to (or as a con equence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-trar Due to (or as a consequence of): attending physician Physician/Medical Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) signed by the at d be detached for P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 X Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No within 24 hours after death.

To the Funeral Director: After this certificate has 1 Yes 2 No director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 💢 No ပ 1 🕅 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 1 X Natural 5 \square Pending Accident Investigation completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

strar's Signature

, Baltimore, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 7714/2011 Marvin Ivan Timmons 1:58 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Worcester Atlantic General Hospital Berlin Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth g Birthplace (State or Foreign Funeral Min Months MD 5/20th 1933 220-28-0873 78 Director Usual Residence of Decedent or 28a-f shov notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes X No MD Ocean City Worcester 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? iral", or items 23a or Examiner must be r Funeral 9935 Elm St. 21842 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: white "natural", Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Poultry [] truck driver of Health and Mental Hygi item 27 is marked other other traumatic event, it Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental of Health and Mental fitem 27 is marked မ Horace Albert Timmons Julie Ann Freeman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norma Jean Timmons (wife) 9935 Elm St. Ocean City, MD 21842 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of H Important: If ite any injury or ott 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Sunset Mem. Park 7/17/2011 Berlin, MD 22. Name and Address of Facility The Burbage Funeral Home 108 William St. , Berlin, MD 21811 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. e death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physiciany ongestive disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner attending physician and for use as the burial-transi Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?

1 Yes 2 No Month Dav Year 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Vital Records, 1 Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 Director: After this certificate 1 🗆 Yes 2 🗆 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 XNo 1 🔀 Inpatient 2 🗆 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at 1 X Natural 5 \square Pending 1 🗆 Yes 2 🗆 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D0064120 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BA5 Atif Zeeshan, AGH 9733 Healthway Drive Berlin M.D 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature State Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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		For State		State of M	arylan			Health and	Mental Hyg	giene 20		24292
		Registrar 1. Decedent's Name ((First. Middle, La	st)	-	Cer	tificate of	Death	2. Date of Dea	Reg. No.		3. Time of Death
Physicia Medic		W	ende		mes	TAY	110n	JR.	Month		Year /	
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Funeral Director		5. Social Security Nun 220–16–970		Sex I X M 2 □ F	e (In yrs. Ia	st birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day APRIL	19, 192		nplace (State or Foreign ntry) RYLAND
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To the Hospital or Attending Physician: The within £4 hours after death. To the Funeral Director: After this certificate I completed filled in by the funeral director, page	Medical	(Check 2	Medical Exam	ysician: To the best o niner: On the basis of rse Practioner: To the	examination	and/or invest	igation, in my opir	ion, death occurred	at the time, date a	ind place, and o	due to the c	ause(s) and manner stated.
To the within To the compl	Σ	only one) 3 L 29b. Signature and til)	, Dear OI III)	Milowieage, (29c. Licen	se number		29d. Date sign		
7		30 Name and address	ss of person who	completed cause of	death (Item	23a) (Type. F	Print)	3605	/	//1	1 1 / 1	
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Stat Registra	te ar	31. Date filed (Month,	TUL 14	32. Regist	ars Signat	A. A	South	<u> </u>				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 24293 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2<u>011</u> Physician/ Month July Evelyn L. Traylor 6:40 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Davidsonville Anne Arundel Rutherford Manor Assisted Living . Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign Days 1 🗆 M 2 📉 F (Month, Day, Yea 2/5/1919 Vermont Director 92 008-10-1081 Usual Residence of Decedent show 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. "natural", or items 23a or 28a-f sho edical Exaπiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 XNo Maryland | Davidsonville Anne Arundel 10e. Street and Number 10g. Citizen of What Country? Funeral 3717 Nile Road 21035 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 X Widowed 4 Divorced White d Mental Hygiene. marked other than "natura matic event, the Medical E. Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Assistant Federal Government item 27 is marked othe other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Janie Erwin Eugene Lumnah 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4905 Colonel Addison Pl., Upper Marlboro, MD 20772 Jane M. Hauser/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 s
Department of H
Important; If ite
any injury or ot
once, 1 N Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place. Lakemont Cemetery 7/23/11 Davidsonville, MD 21. Signatur of Frineral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Congestive Heart Failure disease or condition vears Medical resulting in death) Due to (or as a consequence of): Examiner 5 years Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Directo for as a nonsequence of, that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last the burial-transi Due to (or as a consequence of): Physician/Medical Box 68760 signed by the attending particle by the detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Pregnant at time of death g Unknown g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 X No death? After this certificate 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical completed filled in by the funeral director. Certificate: To Be 26. Place of Death (Check only one) Hospital: Other: 4 \square Nursing Home 5 \square Residence 6 X Other (Specify) 1 ☐ Yes 2 💢 No Assisted 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Living 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours a Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

0H8M

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

13 2011

M.D.

32. Registrar's Signature

Michael R. Freedman,

JUL

31. Date filed (Month, Day, Year)

D52245

116 Defense Highway, Annapolis, Maryland 21401

July 12, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1 - State Amend Item 25 per me, g918,08/18/2011dhb
Registrar

Reg. No. 2. Date of Death Physician/ emme 20 waro Medical 4a. Facility Name (if not institution, give st 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 01 (In yrs. last birthday) Yrs 8. Date of Birth (Month, Day, Yea 9. Birthplace (State or Foreign Country) If Under **Funeral** Months Hours Min. Director Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location any injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No 10g. Citizen of What Country? 10e. Street and Number Funeral Montana items 23a 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 \square Never Married 2 \square Married and Mental Hygiene. is marked other than "natural", or þ Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Plumber 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Temme 21620 19a. Informant's Name/Relationship (Type, Print) City or Town, State, Zip Code) 19b. Mailing Address (Street and Number or Rural Route Number permit. Page 1 and 2 st Department of Health a Important: If item 27 is 02201 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 1 Burial 2 Cremation 3 Removal from State DirectC 4 Donation 5 Other (Specify) rematon Dover ice Licensee ArtoWa. 21. Sig 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final INTER CROWNER HEMORRHA9 Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or iinjury Due to lor as a consequence of ending physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician CERTIFICATIO Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Box (3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No þ Month Year Day Pregnant at time of death 5 Other (specify) been signed by the should be detached g | Unknown g Unknown P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has I completed filled in by the funeral director, page 2 s autopsy perform Yes 2 death? 1 ☐ Yes 2 No **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital မ Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b Time of 28c. Injury at 28d. Describe how injury occurred Medical Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

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31. Date filed (Month, Day,

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32. Registr r's Signature

30. Name and address of person who completed cause of death (Item 23a), (Type, Print)

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JACO/35

DO071130

CHESTERTOWN

5.2011

21620

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of Mar	yland / D	epartmen	t of Hea	alth and M	lental Hyg	jiene	11	24295
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	Examin	er 4	a. Facility Name (if not institution,	/ //	41	1	urel					Jeorge's
		5		6. Sex 7. Age (I	n yrs. last birth	day) If Under	1 Year If	Under 24 Hrs.	8. Date of Birt (Month, Day	n	g. Bird	hplace State or Foreign
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õ	death se atte	sicis	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 ☐ Pregnant at g ☐ Unknown	time of death	5 Other (s	specify)					
<u>.</u>	t the	Phy	9 Unknown Part II. Other significant condit	ions contributing to death br	ut not resulting	in the underlying	g cause give	en in Part I.	23e. Did	tobacco us	e contribute	to the cause of death?
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/ita	Physician: this certific ral director,	To Be	examiner?	Unanital:	ent 2 ER/C	Outpatient 3 🗆	DOA Other	4 Nursing	Home 5 Re			pecify)
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/isi	l or Attendater deat Director:	Certificate:		d not be mined 28e. Place of Inju- building, etc	ury - At home, t c. (Specify)	farm, street, facto	ory, office		City or T	own, State)	Tydiffiber or	Tidate House Harrison,
ă	Hospital or 24 hours afte Funeral Dir sted filled in		100 151	ng Physician: To the best of	my knowledge	death occured	at the time.	date and place,	and due to the	cause(s) an	d manner as	stated.
	Hospital 24 hours Funeral I eted filled	Medical	29a. Certifier 1 Certifyir (Check 2 Medical	ng Physician: To the best of Examiner: On the basis of e ng Nurse Practioner: To the	examination and	/or investigation, wledge, death oc	in my opinion curred at the	n, death occurred time, date and p	d at the time, dat lace, and due to	e and place, the cause(s	and due to to and manner	he cause(s) and manner states as stated.
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Ž	only one) 3 L Certifyii 29b. Signature and title of certifi		200. 07.11) 1110	2	9c. License	number		29d. Dat	e signed (Mo	onth, Day, Year)
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	St	ate	31. Date filed (Month, Day, Tear)	37 Registr	ar's Signature	backer						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2011 Physician 10:54 p M Esperanza Uehara July 13, /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Montgomery Rockville Hebrew Home of Greater Washington | Months | Days | Hours | Min. | B. Date of Birth (Month, Day, Year) | Dct. 30, 1916 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Funeral 1 ☐ M 2 🖾 F Cuba 94 217-72-0384 **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 ☐ No **Funeral Director** Montgomery Rockville 10g. Citizen of What Country? 10e. Street and Number 20852 USA 11919 Parklawn Drive, #301 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 4. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ★No If Yes, Give Year or Dates: Specify White 1 ☐ Never Married 2 ☐ Married 1⊠Yes 2□No Specify: Cuban Baltimore, Maryland 21215-0036 Completed by 3 ☑ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lucinda Mendez Arsenio Perez 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Marielena Uehara Collado/Daughter 11919 Parklawn Drive, #301, Rockville, MD 20852 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State July 14 Metropolitan Crematory Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licensee 500 University Blvd. W., Silver Spring, MD 20901 23a. Part1. En ir the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Dementia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Ursease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed Due to (or as a consequence of) attending physician (Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 🗷 No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 🗆 No 1∏ Yes 2 ¥No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: An Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☑ No 1 Inpatient ٩ After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: Injury 1 Natural 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier min tarl D0064871 July 14, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

Rockville

MD

20852

Montrose

6/21

32. Registrar's Signature

Fazli

31. Date filed (Month, Day, Year)

State of Maryland / D tment of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 14 Day VENSON DENISE MARIE July 20T1 12:20P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Washington Park Adventist Hospital Takoma Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🕱 F Months (Month, Day, Year) Hours Min. 578-84-9222 50 Director Washington, DC Dec. Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director District of Columbia Washington 1X Yes 2 No 10f. Zip Code 10g. Citizen of What Country? Funeral 415 37th Place, S.E. #101 20019 USA Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. 1 X Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🖾 No Specify. Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Clerk Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Henry Venson Evelyn Robinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Lucas, (Sister) 622 Eastern Avenue, Rocky Mount, NC 27801 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Lincoln Memorial 07/22/2011 Suitland, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Jordan Funeral Service, Inc. 4001 Benning Rd., N.E., Washington, DC 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only ause on each line Immediate Cause (Final SEPTIC Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner CARDIO GEMC Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine STAGE attending physician and for use as the burial-transit that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, Hospital or Attending Physician: The law requires cate has been sig page 2 should b 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No Yes 2 A No s after death.

I Director: After this certific d in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: ျာ 14 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a, Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending (Month, Day, Year) 2 Accident
3 Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) notamin, inD 7/14/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHAMIM, MD, WASHMUTON ADVENTUT HOSPITAL TALLONA PARK 31. Date filed (Month, Day, Year) State Registrar

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or with		29b. Signature and title of certifier 29c. License number	CU	-	29d. Date	e signed (A	Nonth, Da	ay, Year) . 2011
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Registrar DHMH 17 Rev 7/2009 32 Registrar's Signature

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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RM Stat		31. Date filed (Monti	h, Day, Year)	32. Registrar's) S Signat	(0()	Lync	r) 111	1194	J. 001	15 2	400	UK	PICTION	M
Registra	ar	,	h, Pay, Year)	11 Assess	A.	A. A	words								

DHMH 17 Rev 7/2009

Funeral Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tem 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Wedical Evantina must be natified at agnee. Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Sta Registr

an	Regina A	(First, Middle						2. Date of Death	Day 12	Year	3. Time of Dea
al						T 41 60 T		July	т —	2011 ty of Death	7:25 A
er	4a. Facility Name (If Somerfor		sted Liv			4b. City, Town,	or Location of Death Annapolis				rundel
	5. Social Security Nu 214–26–035	ımber	6. Sex 1 ☐ M 2/CK F	7. Age (In yrs. 84	last birthda Yrs.	y) If Under 1 Yea Months Days		8. Date of Birth (Month, Day, July 8,	Year) 1927	Cour	olace (State or For ntry) ryland
<u>.</u>	Usual Residence of I 10a. State Maryland	10b. County	e Arundel	10c. Cit	ty, Town or		napolis			1	0d. Inside City Lii
Director	10e. Street end Num 2717 Riv		3			10f. Zip Code	21401	1	0g. Citizen of	f What Cour	
by Funeral	11. Marital Status 1 □ Never Marrie 3 ▼Widowed 4	ed 2□ Marri	12. Was Dec Armed Fo	XX No ive	.S. 13	I Was Decedent of If Yes, specify Cu	Hispanic Origin? (Sp ban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Ra	ace - Americ ack, White,	
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Be	12 17. Father's Name (# J. Edwar				<u> </u>		18. Mother's Nam		Maiden Surna		
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	20a. Method of Dispo 1X Burial 2 4 Donation	Cremation	3 ☐ Removal from	۵. ا د	cemetery, ci	position (Name of rematory or other p nedral Cer	netery 7/1		20c. Location Baltin	•	
	21. Signature of Fur	nefal Service	icensee				ress of Facility Jo				
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Examine	Sequentially list con- if eny, leading to immoduse. Enter Under Cause (Disease or in that initiated events resulting in death) La		c	(or as a conseq				_			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	State Registrar	26 per verb.,	ggt7,0 Cer	tificate of D	l anb Death		Reg. No.	2011	243	UI
			Decedent's Name (First, Middle, Last,					2. Date of De	ath		3. Time of	Death
	Physicia Medic		Mary Louise	Ze11				Jďľÿ	20°,	201 °T	2:40	Ам
	Examin		4a. Facility Name (if not institution, give s	treet and number)		4b. City, Town, or	Location of Death			County of Death		
\mathcal{L}			3304 Matzen Court			Middleto				Frederic		
	Funeral Director		377-40-3374	7. Age (In yrs. le	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir March Da		1935 Was	nplace (State or Hingtor	
	how at	卢	Usual Residence of Decedent 10a, State 10b. County	10c. Cit	y, Town or Lo	cation					10d. Inside Cit	y Limits
	arylar a-f s ified	ect	DE Sussex	Sel	byvill	_e					1X Yes	2 🗆 No
	or 28 or 28 e not	흐	10e. Street and Number			10f. Zip Code			10g. Cit	izen of What Co	untry?	
	with s 23a ust b	Funeral Director	36772 Bluewater B	Run W		19975			Unit	ed Stat	es	
	death item ier m		THE TOTAL STATES	12. Was Decedent Ever in U.S Armed Forces?	S. 13. \	Was Decedent of His f Yes, specify Cubar	spanic Origin? (Spen, Mexican, Puerto	ecify Yes or No- Rican, etc.)		14. Race - Amer Black, White		
0036	be filed within 72 hours after death with the Maryland with Hygiene 14 hours after death hygiene 4 hours 28a or 28a-f sho ked other than "natural", or items 28a or 28a-f sho is event, the Medical Examiner must be notified at	ted by	1 ☐ Never Married 2 ☐ Married 3 🏋 Widowed 4 ☐ Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates.	1	☐ Yes 2X No	Specify:			Specify: Whi		
5	72 hor	Completed	15. Decedent's Ed (Specify only highest grad		(Give i	dent's Usual Occupa kind of work done di	ation uring most of work	ing	16b. K	ind of Business I	ndustry	
12	ithin 7 ene. • than he M	Con	Elementary/Seconday (0-12)	College (1-4 or 5+)	Homen	0 NOT use retired)			Own	Home		
ο Ο	led w Hygi other ent, i	Be	17. Father's Name (First, Middle, Last)		1 Homen	Iditel	18. Mother's Nam	e (First, Middle,	1			
lan	d be fi dental rrked tic ev	욘	Thomas Patrick O'(Connor			Mary Loui	se More	elano	i		
lary	should and N is ma auma		19a. Informant's Name/Relationship (Typ	oe, Print)	19b. Mailir	ng Address (Street a	and Number or Rura	al Route Numbe	er, City or	Town, State, Zip	Code)	
Σ.	and 2 should be fil Health and Mental em 27 is marked o ther traumatic ew			ughter)		Matzen Ci					_	
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify,	Removal from State	Place of Disponentery, crent e of I	sition (Name of natory or other place Ieaven Cer	n. July	25,201	l .	cation - City or Lver Spr)
Balt	permit. Depart Import any inj		21. Signature of Funeral Service License		1 K	Name and Address eeney & E 06 E. Chu	s of Facility Basford P urch Stre	A. Fur	neral ederi	Home ck, Mar	yland 2	1701
			23a. Part 1. Enter the disease, or composhock, or heart failure. List only on		h. Do not ente	er the mode of dying	g, such as cardiac	or respiratory a	rrest,		Approximate Interval Beta	e ween
7	h, sician/	9 3	Immediate Cause (Final disease or condition	e cause on each line. a. Due to (or as a consequ	atro	Biliany	Care	inom .	?		mmfe	eath
mark the	Medical Examiner		resulting in death)	Due to (or as a consequ	uence of):	/						
		er	Usqueritially list conditions, if any, leading to immediate	Due to (or as a consequ	uence of):				_			
	ted I nsit	Examiner	cause. Enter Underlying Cause (Disease or linjury									
	tificate be executed ng physician and as the burial-transit		that initiated events resulting in death) Last	Due to (or as a consequ	uence of):							
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8760	± 5, α	Mec	IF FEMALE:									
9 X	ath cert attendin for use	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna	aldeath 3	Ectopic pregnanc	у		Ī	23d. Date of del Month	-	Year
Вох	e dea the at hed fo	Physician/	1 ☐ Yes 2 🕰 No 9 ☐ Unknown	4 ☐ Pregnant at time of a g ☐ Unknown	death 5 L	Other (specify)				World	Duy	
P.O.	hat th ed by detac		Part II. Other significant conditions co	ntributing to death but not res	sulting in the ι	nderlying cause giv	en in Part I.	23e. Did	tobacco i	use contribute to	the cause of d	eath?
S,	uires t sign lid be	d by						1 🗆	Yes 2	X No 3 □ P	robably 4 🗆	Unknown
oro	w requ	Completed						24a. Was		24b. Were au	topsy findings a	available
ဒ္ဓင	he lav Ite hav vage 2	mo						auto perf 1 🗆 Yes	ormed?	death?	2 No	ause of
a a	ian: T rtifica ctor, p	Be C	25. Was case referred to medical examiner?			26. Pla	ace of Death (Chec		2 0 11	<u> </u>		
₹	hysic his ce I direc	10 E	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐			er: 4 🗌 Nursing H	ome o la R es	idence 6	Other (Spec	of the lange of th	iters
Division of Vital Records,	d ing P h. After tl funera	Certificate:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	work'		28d. Describe	how injur	y occurred		
sio	Atten	rtific	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At no			100 2 2 110			d Number or Ru	ral Route Numb	per,
<u> </u>	al or s s after il Dire		4 - Horricide determined	building, etc. (Specify	/)			City or To	wn, State)		
_	To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death the within 24 hours after death the service of the this certificate has been signed by the attendit completed filled in by the funeral director, page 2 should be detached for use	Medical	(Check 2 Medical Examilia	ician: To the best of my know ier; On the basis of examinatio	n and/or inves	tigation, in my opinio	n, death occurred a	at the time, date	and place	e, and due to the	cause(s) and ma	inner stated.
	the lithin 2 the lomble	M	only one) 3 Certifying Nurse 29b. Signature and title of certifie	e Practioner: To the best of m	y knowledge, o	death occurred at the		ce, and due to t		s) and manner as ate signed (Monti		
	⊢≥⊭ŏ)			D43	091		7-	20-11		
			30. Name and address of person who co	ompleted cause of death (Iten	1 23a) (Type, F	Print)	<i>i</i> 1 .	- /		4	45 t 16m	70
	15		Sacral Zaridi	ompleted cause of death (Item	TOLL	House	HVE (Heder	rick	MA	21/0	7/
	Stat Registra	te ar	31. Date filed (March, Day, Year) 2011	32. Registrar's Signa	gav	les						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2011 24302

	1- For Regis		•	Ce	rtificate	of Dea	ath		7.5	Reg. N	0.	• •	L 4001
Physician	1. De	edent's Name (First, Mic							2. Date of Month	Day	y Year		3. Time of Death
Medical Examine	110	rk Allen Av				1	_		July 25	, 2011			0934 hrs
		cility Name (if not instituted in the control of th	. •	iumber)			nerstow	r Location of [eath		4c. County of Washing		
Funeral		ial Security Number	6. Sex	7. Age (In yrs.	last birthday)		nder 1 Yea		4Hrs. 8. Date o	f Birth/M			place (State or
Director			1 <u>X</u> M 2_F		4 15	Mor	nths Day		Min.			Foreign Cour	
		6-02-0914 Residence of Decedent	I A IVI 2 F		1.7	Yrs.			06/.	14/19	196	0001	NJ NJ
404	10a. S		У	10c. City	, Town or Lo	cation						1	10d. Inside City Limits
be altow	NJ	G1 ou	cester	Man	itua								1 XYes 2 No
the Maryland a or 28s-f show tiffed at occ.	10e. 9	treet and Number				10f. Z	Zip Code			10g. C	itizen of Wha	at Count	ry?
the National Street		5 Sherwood	Place			0	8051				USA		
eath with the ! items 23a or ust be notifie	11. M	rital Status	12. Was De	cedent Ever in U		Was Dece	dent of Hi		(Specify Yes o	r No-	14. Race -		an Indian, Black,
or ite		Never Married 2 1	1 Yes	2 X No		res, spe	CITY CUDA	n, Mexican, Pi	uerto Rican, etc.)		White,	etc.	
s after	S 3 -		ivorced If Yes, Give Ye or Dates:		1			specify:			Specify:	B1a	
hour natu	B 13. 1	ecedent's Education (Sp mentary/Secondary (0-12		(1-4 or 5+)	16a. Deced	lent's Usua most of w	al Occupa vorking life	tion (Give kind a. DO NOT use	d of work done e retired)	16b	. Kind of Bus	iness/Ind	dustry
136 hin 73 than dical		8	College	(1-7-01-31)		C+	dent				Mar		
d with	17. Fa	ther's Name (First, Middl	e, Last)		L	Sta	dent	18.Mother's N	lame (First, Midd	le, Maide		VEL V	worked
MD 21215-0036 d 2 should be filed within 7 th and Mental Hygiene. n 27 is marked other than rumatic evect, the Medical		rk A. Avant	, Sr.					Michel	lle A. G	roar	k		
Men man	19a. li	formant's Name/Relation			19b. Mail	ing Addre	ss (Stree		r or Rural Route			, State, 2	Zip Code)
AC of d 2 st lith an lith an 177 in uma		rk A. Avant	, Sr fa		605	Sher	wood	Place,	Mantua				
nore, MD 21215-0036 ages I and 2 should be filed within 72 hours after death with the Maryland it: If titen 27 is marked other than "ustural", or items 23a or 28a-f sho other traumatic eveot, the Medical Examiner must be notified at once. TO Be Completed by Engage Director		ethod of Disposition Burial 2 Crematic	on 3 Removal f		Place of Disp crematory or				Date 08/01/20		. Location - 0	City or To	own, State
Page Page ment of		Donation 5 Other			iladel	phia	Cre		es, Inc.		hilade	1phi	ia, PA
Baitimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 77 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic evect, the Medical Examiner must be notified at occurring the Commission Hyperbary.	21. Si	Funeral Service	e Licensee					of Facility					ne, P.A.
	200 5	Trail.	////	-	11	.11 S	. Que	en Sti	eet. Ri	sing	Sun.	MD 3	21911
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Examiner	Immed or cor	liate Cause (Final diseas dition resulting in death)		ant star	hyloc	occus	aur	eus				\rightarrow	Death
		ntially list conditions,	b.	a consequence o	··).								
à	if any,	Isading to immediate Enter Underlying Cause		a consequence o	T).							- 1	
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Box 68760, death certificate be the attending physic of for use as the burnwaician/Med	IF FEN		23c. If yes,	outcome of pregi	nancy					2	3d. Date of d	elivery	
OX 687 eath certifi attending for use as t	23b. vv	as decedent pregnant in st 12 months?	Live	birth nant at time of de	eth =	Fetal death		Ectopic pro	egnancy		Month	Da	y Year
). Box 68 the death certiful the death certiful the death certiful to the death certiful the death certiful the death certiful the death d	1 🗆	Yes 2 No 9 Ur	nknown 9 Unkn		5	Other (Sp	ecify)						
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Records, The law requires fricate has been signage 2 should be									24a. W	as an			psy findings available
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Physiciae: r this certificated director, To Be (9 exa	miner? ✓ Yes 2 No	Hospital: 1	Inpatient 2	ER/Outpatie	nt 3 🗌	DOA	Other No	ursing Home 5	Resid	lence 6	Other:	
Division of ' pital or Atteoding Ph pura after death. eral Director: After t filled in by the funeral Certification: T		nner of Death	28a. Date (Mont)	of Injury n, Day,Year)	28b. Time o	f Injury	28c. Inju	y at Work?	28d. Descri	be how in	jury occurred	1	
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Division o ospital or Atteoding hours after death. overal Director: Aft. y filled in by the fune Certification:	з 🗌		lid not be	ce of Injury - At ho	ome, farm, str	eet, factor	ry, office b	uilding, etc.		n (Street n, State)	and Number	or Rura	Route Number, City
Hospita 24 hours Fuocral stely fille		Homicide	(Specify)						4				_
9 - 3		ertifier		st of my knowledd	ge, death occ	urred at th	ne time, da	ite and place,	and due to the c	ause(s) a	ind manner a	s stated	
2 1 2 2 E		only Certifying P	Physician: To the bes aminer: On the basis	of examination ar	nd/or investig	jation, in m	ny opinion	, death occum	ed at the time, da	ate and p	idoo, aria aac	e to the t	cause(s)
To the Hospital within 24 hours. To the Fuoeral completely filled Medical Cert	(Check one)	only Certifying P	aminer: On the basis and manner s	of examination ar	nd/or investig		9c. Licens		ed at the time, da		. Date signed		
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To the H within 24 To the F/ Completel	29a. C (Check one) 29b. S	2 Medical Ex	aminer: On the basis and manner s er	of examination ar stated.			9c. Licens	e number	ed at the time, da	29d	. Date signed	(Month	
Fo the Howithin 24 Po the Forthe	29a. C (Check one) 29b. S. 30. Na	2 Medical Excorporature and title of certific	aminer: On the basis and manner s er	of examination ar stated.	23a)	29	9c. Licens	e number M.E.	altimore, MD	Jul	Date signed y 26, 201	(Month	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 24303 Reg. No 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Thomas Wonnell Bounds July 9:15 AM 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Berlin Nursing Home Berlin Worcester Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Aug 18 (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 € M 2 □ F Months Days 213-22-6468 8.5 Country) **Director** 1925 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 ☐ Yes Ž☐ No Worcester Newark 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7241 Five Mile Branch Road 21841 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married ğ is, Tilumas re, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed 3 Widowed 4 Divorced white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver EM Jones Trucking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Rodney C. Bounds Bessie Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary L. Bounds-Wife 7241 Five Mile Branch Road Newark, MD 21841 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Bowen Cemetery 7-20-11 Newark, 22. Name and Address of Facility Burbage Funeral Home 21. Signature of Funeral Service Licens 108 William Street Berlín, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Due to for as a consequence of Cause (Disease or iinjury physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 attending p IF FEMALE: . If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Month Dav Year Pregnant at time of death 9 Unknown 9 Unknown I or Attending Physician: The law requires that the after death.

Director: After this certificate has been signed by th Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, Certificate: To Be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗶 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 XNo Other: 4 X Nursing Home 5 A Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 1 X Natural 5 Pending injury 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signaty 29d. Date signed (Month, Day, Year) July 18, 2011 R 135131

Registrar

State

9715 Healthway Dr.,

Berlin,

MD

21811

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 8 2011

Registrar's Signature

Pennie Savage, CRNP

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 24304 Reg. NZ Registra Amend#23a&part ITPerPhys. PCC7-19-11c Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Benedicto July O1 2011 0730 Denise Juliette Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Silver Spring Holy Cross Hospital Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** August 24 037-20-3431 Yrs 86 France **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location aţ 10d. Inside City Limits death with the Maryland Director "natural", or items 23a or 28a-f s edical Examiner must be notified Gaithersburg 1 X Yes 2 No MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20877 United States #408 9 Chestnut Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc 1 Never Married 2 Married by within 72 hours after Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White Completed 3XXWidowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) National Paint Elementary/Seconday (0-12) College (1-4 or 5+) filed within all Hygiene. the Director & Coatings Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental H 27 is marked or traumatic ever ဂ Emilie Isabelle Chalifour Marcel Victor Robert permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Philip John Benedicto-Son 6400 Brass Button Ct. Centreville, VA 20121 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Arlington, VA Columbia Gardens July 5,2011 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licens 22. Name and Address of Facility matur Dru Murphy FH 4510 Wilson Blvd. Arlington, VA 22203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause an each line. Immediate Cause (Final Onset and Death Ph_sician/ espira disease or condition Medical resulting in death) Examiner emorgh Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence or) or Attending Physician; The law requires that the death certificate be executed the burial-transi Cause (Disease or iinjury that initiated events Urinary Tract Infection and Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Chronic Kidney Infection Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Dav Year 4 ☐ Pregnant at time of death 9 ☐ Unknown signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Diabetes 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of Hypertension 24a. Was an page 2 s has autopsy performed death? certificate Hypothyroidism 2 No 1 🗌 Yes Yes 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 I ER/Outpatient 3 I DOA this completed filled in by the funeral 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) Certificate; 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 5 Pending work? 2 🗌 No Accident Investigation Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 🗆 Certifying Nurse Practioner: To the best 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D19563 07, 01, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Purnima Joshi
31. Date filed (Month, Day, Year)

1 9 2011

1500 Forest Glen Rd. Silver Spring, MD

Holy Cross Hospital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hydiene O. I. I

		-	For State Registrar	State Of Ivia	aryland / L	Certii	ficate of L	Death	vientai i iy	Reg. No			24305
Phys M	siciar ledica		1. Decedent's Name (First, Middle, Last)	Jean A. Br	ooks				2. Date of De		111 Year	,	3. Time of Death 11:05 Р м
and the same of th	mine		4a. Facility Name (if not institution, give sti			4		Location of Death		40	County of De		rge's
Fune Direc	_		5. Social Security Number 6. Sex		(In yrs. last birth		f Under 1 Year lonths Days	If Under 24 Hrs. Hours Min.	8. Date of Bir Month, Da Feb 23	th , 195	9. E 5 Wa	Birthpla Country Shill	ace (State or Foreign
Maryland 28a-f show	lotifiled at	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Prince Geor	ge's	10c. City, Town	n						10	d. Inside City Limits
with the	ner per	Funeral D	10e. Street and Number 6905 Eilerson Street				10f. Zip Code 207 3	35		10g. C	tizen of What (
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other tranmatic event, the Machinal Evaniner must be notified at	i Examiner m	<u>م</u>	11. Märital Status 1 Never Married 2 XMarried 3 Widowed 4 Divorced	2. Was Decedent Ev Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates.		If Ye	Decedent of Hi es, specify Cuba	ispanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		14. Race - An Black, Wh Specify:	nite, et	
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If free T? Is marked other than "natural", or may injury or other traumatic event, the Modical Exami	the Medica	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Seconday (0-12) 12) (Give kind	IOT use retired)	ation during most of work	ing		Kind of Busines		estry Estate Co.
/land deliber of the same of t	ric event,	P Be	17. Father's Name (First, Middle, Last) William F. Schroth					18. Mother's Nam Betty	ne (First, Middle, B rown	<i>Maid</i> en	Sumame)		
Mary nd 2 shoul ealth and 1 m 27 is manned to a manned	ler traume		19a. Informant's Name/Relationship (Type Bobby Brooks (husband					and Number or Rur Street, Cli				Zip Co	de)
imore Page 1 ar ment of He tant: If iter	ury or our		20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	emoval from State	20b. Place of I cemetery Maryland	cremato	any or other place	etery July	Date 22, 2011		ocation - City o 1tenham,		n, State
Balt permit. Depart Import	once.		21. Signature of Funeral Service Licensee	moo		F€	erry Road,	Clinton,	MD 20735		nc 6633	01d	Alexandria
Physicia Medic	cal		23a. Fart 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	ations that caused cause on each line. Due to (or as a	rage	t enter th	A A	g, such as cardiac	1 4		dyn	11/1	Approximate Interval Between Oncet and Death
Examir		_ 	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		consequence of	<u>l v</u>	cer(s'	75				-	
8760 ificate be executed ig physician and as the burial-transit		Exa	Cause (Disease or linjury that initiated events c. resulting in death) Last	-	consequence of		yeer					-	_ -
8760 ifficate be ng physic as the bi		Nedical	d.									\perp	
OX 68 ath cert attendir for use		€ I	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 X No 9 Unknown	c. If yes, outcome of 1 Live Birth 2 4 Pregnant at 9 Unknown	Fetal death		ctopic pregnanc ther (specify)	у			23d. Date of o		y day Year
ords, P.O. Bo requires that the de been signed by the s should be detached	_	2	Part II. Other significant conditions conti	ributing to death bu	t not resulting in	the unde	erlying cause giv	en in Part I.		obacco i	•		cause of death?
Tital Records, sician: The law requires certificate has been significator, page 2 should b		Completed							24a. Was autop perfo 1 Yes	osv	prior to	com	y findings available pletion of cause of
Vital ysician ysician is certifi	3	o Re	25. Was case referred to medical examiner? 1 Yes 2 No	spital:	nt 2 🗆 ER/Outp	atient 3	Lou	ace of Death (Chec er: 4 Nursing Ho		dence 6	Cother (Spe	ecify)	
Division of Vital the Hospital or Attending Physician: hin 24 hours after death. the Funeral Director. After this certific mpleted filled in by the funeral director,			27. Manner of Death 1 A Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day,	28b. Tir	ne of ary	28c. Injury work	at	28d. Describe h			scryy	
Division Atture of a price of a p			3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc.	(Specify)				28f. Location (S City or Tow	n, State)		oute Number,
DIVI To the Hospital or within 24 hours afte To the Funeral Dire completed filled in the		Med	only one) 3 L. Certifying Nurse F	an: To the best of m COn the basis of exa Practioner: To the be	mination and/or i	nvestigat	ion, in my opinion h occurred at the	n, death occurred a e time, date and plac	t the time, date a	ind place	, and due to the	e caus	e(s) and manner stated.
70 wit			29b. Signature and title of certifier.	. alle	ely		29c. License	24208		29d. Da	te signed (Mon	th, Da	y, Year)
182			30. Name and address of person who com ABULHAS A	pleted cause of dea	ith (Item 23a) (Ty	pe, Print)	113	inte	~M	d 6	200	35	
Regi:	State istrar		JUL 19 20	32. Registrar	s Signature	A Car	a stant					-	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Maryl	•	rtment of tificate of		and Mer		iene eg. No 20		24306
Ī	Physicia Medic		1. Decedent's Name (First, Middle, Last) Emma Ann Busick						Date of Death Month $11 \mathrm{y} - 1$	Day	Year 011	3. Time of Death 5:25 A M
	Examir	er	4a. Facility Name (if not institution, give stre Mallard Bay Care	Center			nbridge)		4c. County Dor	ches	
	Funeral Director		5. Social Security Number 212-18-6026 Usual Residence of Decedent	7. Age (In yi	rs. last birthday)) Yrs.	If Under 1 Yea Months Days			Date of Birth Month, Day arch 2	8,1921		place (State or Foreign try) Laware
3	th the Maryland 3a or 28a-f shov	rector	10a. State 10b. County Dorchest		City, Town or Loc		bridge				1	0d. Inside City Limits 1 X Yes 2 No
S	with the rs 23a or 2	Funeral Director	10e. Street and Number 520 Glenburn Aven	ue		10f. Zip Code	21613			0g. Citizen of W	hat Coun	
-0036	e flied within 72 hours after death with the Maryland ttal Hygiene. 3d other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at	Completed by Fur	1 ☐ Never Married 2 ☐ Married 3 🖫 Widowed 4 ☐ Divorced	Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates.	1	/as Decedent of Yes, specify Cul	lo Specify:	in? (Specify ` Puerto Ricar		Specify:	white, o	te
Maryland 21215-0036	within 72 he giene. er than "ne , the Medic	Comple	15. Decedent's Educa (Specify only highest grade of Elementary/Seconday (0-12)		(Give k	ent's Usual Occu ind of work done NOT use retired homemake	e during most o d)	of working		16b. Kind of Bu	home	•
yland	should be filed within a nand Mental Hygiene. I is marked other than aramatic event, the M	To Be	17. Father's Name (First, Middle, Last) Benjamin Earl Ti	ngle				's Name (Firs		aiden Surname, ngham		- 10
e, Mar	ge 1 and 2 should be it of Health and Men if item 27 is marke or other traumatic		19a. Informant's Name/Relationship (Type, William T. Busick	son	Ρ.	O. Box				-		iode)
Baltimore,	permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau		20a. Method of Disposition 1 ☐ Burial 2 🗵 Cremation 3 ☐ Rer 4 ☐ Donation 5 ☐ Other (Specify)	noval from State	rematory	of Delr	narva	7/15,	/11	De1ma	r, D	E
Bal	Depar Impo any ir		21. Signature of Funeral Service Licensee	>	70	Name and Addr	st St.,	Cambi	ridge,		me P 613	.A.
	Physician/ Medical Examiner		23a. Part 1. Enter the disease, or complicat shock, or heart failure. List only one or immediate Cause (Final disease or condition resulting in death)	tions that caused the drause on each line. Clemen7 Due to (or as a cons	tia	the mode of dy	ing, such as ca	ardiac or res	piratory arres	t,		Approximate Interval Between Onset and Death
	ecuted and -transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of inique) that initiated events resulting in death) Last	Due to (or as a cons								
09/	ate be exemply sician the burial	edical E	d	— Due to (or as a corrs	equence on.				_		_	
. Box 687	Hospital or Attending Physician: The law requires that the death certificate be executed 4 hours after death. Funeral Director: After this certificate has been signed by the attending physician and ted filled in by the funeral director, page 2 should be detached for use as the burial-transit.		in the past 12 months?	If yes, outcome of preg 1 Live Birth 2 F 4 Pregnant at time of 9 Unknown	etal death 3 🗌	Ectopic pregnal Other (specify)	ncy			23d. Date Mor	of delive	ery Day Year
ls, P.O.	uires that the dec n signed by the a lid be detached f	ed by Pl	Part II. Other significant conditions contrib	outing to death but not	resulting in the un	derlying cause g	given in Part I.		23e. Did toba			ne cause of death?
Division of Vital Records,	ician: The law require certificate has been si rector, page 2 should k	Completed by					-		24a. Was an autopsy perform 1 Yes 2	/ p		osy findings available mpletion of cause of
f Vital	Physician: this certifica al director, p	To B	25. Was case referred to medical examiner? 1 Yes 2 No Hosp	1 Inpatient 2		3 □ DOA Ot				nce 6 🗌 Other	· (Specify))
sion o	il or Attending F s affer death. I Director: Affer d in by the funer	Certificate:	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	28a. Date of injury (Month, Day, Year) 28e. Place of Injury - At			rǩ? ☐Yes 2☐N	10		v injury occurre		Doub Number
Divi	spital or A lours after leral Direc filled in by	cal Cel	4 Homicide determined 29a. Certifier 1 Certifying Physician	building, etc. (Spec	cify)			(City or Town,			
	To the Hospital of whithin 24 hours at To the Funeral D Completed filled in	Medical	(Check 2 Medical Examiner: only one) 3 Certifying Nurse Pr	On the basis of examina	tion and/or investig	gation, in my opin	nion, death occi	urred at the ti	me, date and	place, and due	to the cau	use(s) and manner stated ated.
•	2		30. Name and address of person who comp	leted cause of death //t-	em 23a) (Type, Pr	Hoo	599	73		7/141	/1/	
	Stat		Patricia John 50 31. Date filed (Month, Day, Year)	DO DO Registrar's Sign	100 B1	amble	Car	nbrio	tse,	MD		
	Registra		JUL 15 2011	Come	p. pa							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, for State Registrar 24307 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2011^{Year} Physician/ July 8 4:00 a^M Mary M. Crowley Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Rockville 4c. County of Death
Montgomery Examiner Shady Grove Adventist Hospital Social Security Number If Under 1 Year If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 XF Hours March Day 022-01-2269 ⁷1918 Massachusetts Director Usual Residence of Decedent r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director PA Huntingdon Hesston 1 Yes 2 No 10e, Street and Number 10f. Zip Code ō 10a. Citizen of What Country? must be Funeral 23a 16647 USA 12945 Lakeland Drive items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 9 ò 1 Yes 2 No If Yes, Give Year or Dates. 1 Never Married 2 Married 1 Yes 2 Tho Specify Specify: White "natural" 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) home-maker own home Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be file ment of Health and Mental I ant: If item 27 is marked o ပ္ Sara Meehan Nelson H. Manning 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Penny Igoe, daughter 12945 Lakeland Dr. Hesston, PA 16647 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Department o Important: If any injury or 9 7/27/2011 Alexandria, VA 5 Other (Specify) Everly Crematory 4 Donation Signature Frieral Service Licensee 22. Name and Address of Facility Everly Wheatley Funeral Home 1500 W. Braddock Road, Alexandria, VA 22302 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph. sician/ Failure disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Failur Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or indicate) Examiner attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be 1 IF FEMALE: 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? γ DIFFICIE Clostridium 1 Yes 2 No 3 Probably 4 Hinknown Completed potension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Fibrillation Atrial certificate 1 Yes 2 No 25. Was case referred to medical funeral director, Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital: 2 7 No Other: 1 PInpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Retural 2 Acci 28d. Describe how injury occurred 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined hours after within 24 hours a To the Funeral L Medical

State

0330

1105/8/6

21215-0036

Baltimore,

Division of Vital Records, P.O. Box 68760

Registrar

29a. Certifier (Check

Attan Kasid MD

31. Date filed (Month, Day, Yes 19 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D0055054

6045. Frederick Ave Suite 409 Gaithersburg, NO 20855

July 8,2011

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Box 68760 Ö σ. Records, Vital of Division

DHMH 17 Rev 1/2001

State

Registrar

Medical

completely

within 2 To the I

29a, Certifier

(Check only

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

13

🗠 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

11-05505 Alexander B Crum Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

exander B Crun		Stat 1- For State Registrar	te of Maryla		artment of rtificate of			Menta	al Hyg		20	11	24309
Physicial edical Examin	n/	1. Decedent's Name (First, Middle, L Alexander B. Cr								. Date of Death Month July 23, 20	Dav Yea		3. Time of Death 1944 hrs
		4a. Facility Name (if not institution, 1783 Valleyside Drive	give street and nu	mber)		4b. City, To F rede r		ocation of [Death		4c. County of		
Funeral Director			Sex M 2 F	7. Age (In yrs. I 41	ast birthday) Yrs	If Under Months	1 Year Days	If Under 2 Hours	24Hrs. Min.	8. Date of Birth	,	9. Birth Foreign Mee	nplace (State or n phigan
nd show any ice.	ľ	Usual Residence of Decedent 10a. State 10b. County MD Freder	ick		, Town or Locat derick	ion				1105 120	,1100		10d. Inside City Limits 1 X Yes 2 No
the Maryland s or 28a-f show	Director	10e. Street and Number 1783 Valleyside	Drive			10f. Zip 0					g. Citizen of Wh Jnited		
i 9.51	y Funeral	11. Marital Status 1 Never Married 2 Marri 3 Widowed 4 Divorce		2 X No		rs Decedent res, specify	Cuban, I	Mexican, P		cify Yes or No- ican, etc.)	14. Race White Specify: 1	e, etc.	an Indian, Black,
136 hin 72 hours a e. than "natura	Completed by	15. Decedent's Education (Specify Elementary/Secondary (0-12) 12	only highest grad		16a. Deceder during m	ost of worki					None	siness/In	dustry
215-00 e filed with tal Hygiens ked other mt, the Me	Be Con	17. Father's Name (First, Middle, La							,	First, Middle, Ma	eiden Surname	,	
AD 21, 2 should b h and Men 27 is mar	٩	19a. Informant's Name/Relationship Steve Crum	(Type, Print)	ther)						Godsey ral Route Numb erson, N	Marylan	d 21	755
more, lages land ent of Healt it if item		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other Spec		om State	Place of Dispos crematory or ot thsburg	ner place)		· L			20c. Location - Smiths	-	
Baltic permit. I Departme Imports injury o	1	21. Signature of Funeral Service Lic	censee	MO1612	22 K	lame and A Eney 6 E.	deresses Chui	asford ch S	d P.	A. Fund Freder	eral Ho	me ryla	nd 21701
Physician /Medical		23a. Part I. Enter the disease or co failure. List only one cause on Immediate Cause (Final disease	mplications that called the each line. Mix a. Quetia		Do not enter to Intoxi	he mode of catio	dying, sı n (Me	rtaza	diacorr B, Di	espiratory arres azepam,	t, shock, or hea	one,	Approximate Interval Between Onset and Death
Examiner		or condition resulting in death) Sequentially list conditions,	Due to (or as a b.	consequence o	of):								
1	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	consequence o								-	
recu	dical	X UNPENDED	d	23a,27,2	28a-f,p	er me,	g918	8-15	5–11	sm			
ox 6876(eath certificate statending phys for use as the b		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unkno	1 Live b	ant at time of de	2 Fe	tal death her <i>(Specif</i>	3 [Ectopic p	regnanc	;y	23d. Date of Month	delivery Da	ay Year
P.C es that igned l	출	Part II. Other significant condition	s contributing to	death but not r	esulting in the u	inderlying c	ause giv	en in Part i	1.				ne cause of death? ably 4 Unknown
cords law requ has been 2 should	Completed									24a. Was ar autopsy perform 1 Yes 2	/ p		opsy findings available ompletion of cause of
Vital Reorgians: The his certificate director, page	å	25. Was case referred to medical examiner?	Hospital:	npatient 2	ER/Outpatient			f Death (Cl		ly one) Home 5 R	anidanna 6 L	Z Othor	Saana
of Vitaling Physic	앍	1 ✓ Yes 2 No 27. Manner of Death	28a. Date	of Injury	28b. Time of I			at Work?		8d. Describe ho			Scerie
ᆮᆁᇃᆠᄰᅵ	Certification:	1 Natural 5 Pending 2 Accident Investig	g fd 7-	, Day,Year) -23-11 e of Injury - At he	fd 7:0			s 2 X N		ubject			al Route Number, City
Division Hospital or Atten 24 hours after death Funeral Director: stely filled in by the		Suicide 6 Could n 4 Homicide determi	not be	Resid			anice but	raing, etc.		or Town, Sta	te) 1783		eyside Dr.
To the Hosy within 24 hosy to the Fun completely	egical adical	one) 2 Medical Examin	sician: To the bes ner:On the basis of and manner s	of examination a									
	Ž	29b. Signature and title of certifier Panel Swifts	rell m				D.C.M			1	29d. Date signe July 24, 20		h, Day,Year)
		30. Name and address of person wt Pamela E. Southall, MD		se of death (Item Medical Exa) W. Balt	imore	Street, E	3altim	ore, MD 212	223		
Sta	te	31. Date filed (Month, Day, Year)	32. Re	egiarar's Signati	Irela								

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			FOI	State of Maryland						1 1	21.210
			Registrar		Cer	tificate of L	eath			1 1	1
	Physicia	n/						Month	Day	Year	
	Medic	al				41 CH T	Landing of Dooth	_July_			
")	Examin	er			oinos				1		
	Funoral	77	Social Security Number 6. Sex	7. Age (In vrs. las	st birthday)	If Under 1 Year	If Under 24 Hrs.		1	9. Birth	place (State or Foreign
	Director		046-14-7497	12 ZF 92	Yrs.	Months Days	Hours Min.	03-17-	-1919	Mar	yland
	, A	h	Usual Residence of Decedent	140 00					-		10d Inside City Limits
	ryland -f sh ied at	cto				ation					
	e Ma r 28a notif	Ë		Ea	aston	10f Zin Code			10a Citizan of	What Co.	
Table 1 State Registrar Certificate of Death Reg. N2 0 243 10											
	ems r mu	nu.		. Was Decedent Ever in U.S.	. 13. W	as Decedent of His	spanic Origin? (Spe	cify Yes or No-		e - Amer	ican Indian,
ထွ	ter de , or it mine		1 Never Married 2 Married	1 Yes 2 X No				Rican, etc.)			, etc.
9	ursaf tural" elExa	ted		Year or Dates.						BT	
7	72 ho "nat	胞			(Give k	ind of work done d	ation uring most of worki	ng	16b. Kind of B	usiness Ir	
7	ithin ene. r thar the N	ပ္ပ	Elementary/Seconday (0-12)	College (1-4 or 5+)		_ '	∍r		someon	ne e	I
0	lled w I Hyg othe rent,	Be	17. Father's Name (First, Middle, Last)			1		e (First, Middle, I			
<u>lar</u>	d be f Menta Irked tic ev	잍	Rev. Gilbert	Dudley			Ola		Nasl	a	
lar,	shoulk and N is ma		19a. Informant's Name/Relationship (Type,	Print)	19b. Mailin	g Address (Street a	nd Number or Rura	l Route Number	City or Town,	State, Zip	Code)
<u>,</u>	nd 2 sealth m 27 ner tr										
ore	ge 1 a t of H If ite or oth		,	moval from State Ce	emetery, crem	atory or other place	e)			•	
<u>Ħ</u> .	t. Pag rtmen rtant; rjury			Ric							
Bal	permi Depa Impo any ir	3	21. Signature of Funeral Service Licensee	A.C	22	Name and Addres	s of Facility Ben	nie Sm	ith Fu	ıner	al Home
		_	23a. Part 1. Inter the disease, or complica	tions that caused the death	. Do not ente	r the mode of dying	g, such as cardiac c	r respiratory arm	est,		Approximate
	h sisian/		shock, or heart-failure. List only one of Immediate Cause (Final	ause on each line.							
1			disease or condition resulting in death)	Due to (or as a const	ence of):	re to 1	unve			-	
	Examiner		Conventially liet conditions	Pancrea	tiz (ancer	-				1 year
	- +	ine	d any, reading to immediate cause. Enter Underlying	upperiod a earlo) of edic	ande oi):					- 4	,
	cuted and transi	xar	Cause (Disease or linjury that initiated events c.	Dua to for on a consequent			·				
_	oe exe		resulting in death) Last	Due to (or as a consequi	ence oi).						
160	physics the last	edic	d.	-			-				
89	certifi nding use as	n/M		. If yes, outcome of pregnar	ncy	le.			23d. Da	ate of deli	ivery
SO.	eath of atter	icia	in the past 12 months?	4 Pregnant at time of de			у		М	onth	Day Year
O	the d by the tacher	hys									
<u>.</u>	s that gned be de		11 1	buting to death but not resu	ulting in the u	nderlying cause giv	en in Part I.				
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000	law r has b e 2 sł	mple	mema of a	monic Dis	an			autop	sy	prior to o	completion of cause of
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ita :	siciar certif irecto		examiner?	pital:	50/0:	Othe	ar.		2 🗆 211	(0)	· · ·
<u>5</u>	y Physer this eral d		27. Manner of Death	28a. Date of injury	28b. Time of	28c. Injury	at				<u> </u>
uc :	ath. r. Afte re fun	icat	2 Accident Investigation	(Month, Day, Year)	injury		? Yes 2 No				
ISI/	r Atte ter de recto by th	ertif		28e. Place of Injury - At hor building, etc. (Specify)	me, farm, stre	et, factory, office				er or Rur	ral Route Number,
	urs af ral Di lled ir						1				
:	Hosp 24 hor Fune Fune	edic	(Check 2 Medical Examiner	On the basis of examination	and/or invest	igation, in my opinic	n, death occurred at	the time, date a	nd place, and di	ue to the c	cause(s) and manner stated.
:	o the	Ž		ractioner: To the best of my	knowledge, c						
	->-0		Ma King	FNPR,		RII	12350	j	7	1	111
			30. Name and address of person who com	pleted cause of death (Item	23a) (Type, P	rint)				1	
	3		Stefanic Defiglia		10 D	utchm	ansle	ine E	astor	, m	D 21601
			31. Date filed (Month, Day, Year)	32. Registrar's Signati	ure	Sarl .					
	Registra	ar	JOL 0 (20	11 persua	14. 19						

Gr. ■

Hazel Dudley

DHMH 17 Rev 7/2009

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Stanley Robert Davis, Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JMHS-Regional medical Alleganu umberlanc Center If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** 1 🖵 M 2 🗆 F Months Min 8-27-1935 174~28-3347 Pennsylvania Director 75 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Paw Paw 1 Yes 2 No Morgan 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 25434 32 American Circle USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Maryland 21215-0036 1 Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Forklift Operator Manufacturing 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Samuel Davis Bertha Anthony Gerlach 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25434 32 American Circle Paw Paw, WV Ann Fiore Davis - wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Scarpelli Funeral Home 7/22/2011 1 Burial 2 Cremation 3 Removal from State Cumberland, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee. 22. Name and Address of Facility Kimble Funeral Home 188 Moser Avenue Paw Paw, West Virginia 25434 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Betweer Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and the attending physician and hed for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Year Day 9 Unknown 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ours after death.

leral Director: After this certificate has filled in by the funeral director, page 2.3 autopsy performed? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 No 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier J.l. 19,2011 30. Name and address of persol who completed cause of death (Item 23a) (Type, Print) 924 Seton Drive Vikramaditya Poonai Cumberland, MD, 21502 31. Dăte filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend Item# 30, per DVR g918 8 1-11 smental Hygiene

State

Registrar

2011

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene **1 –** For State Registrar 24312 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Grady L. Edwards July 2011 a 15, 1950 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Hospital P.G. Cheverly 6. Sex 1 ★ M 2 □ F If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 578-82-5762 7. Age (in yrs. last birthday) **Funeral** Days Hours oct. 23, Year) 967 NorthCarolina **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ems 23a or 28a-f sh r must be notified a Md. P.G. Landover 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2340 Vermont Ave. Apt 204 20785 U.S.A. within 72 hours after death with items 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 🌁 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Examiner Black, White, etc. 0 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 K No Specify: "natural", 3 Widowed 4 Divorced De filed whs.
Mental Hygiene.
Set other than "nats.
The Medical Ex Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver Private traumatic event, Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be.
Department of Health and Mental Important: If item 27 is meriany injury or other? and Mental is marked o Wilson Edwards Gladys Worthington 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) wife Wanda Edwards Ingram 2340 Vermont Ave. #204 Landover, M.d.20785 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State GlenwoodCemetery July21,11 Wash., D.C. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Wash., D.C. 20001 22. Name and Address of Facility Robinson Funeral Home Inc. 1313 6th St.NW 23a. Part V. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph sician/ at al cerrythmia disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** arcoldosi Sequentially list conditions, Dis-tator as a nuns-quenter of than, leading to in recitate cause. Enter Underlying Cause (Disease or iinjury that initiated events -transit Exam and Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No signed by the a Id be detached f 9 Unknown Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 ☐ Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate to completed filled in by the funeral director, page 1 ☐ Yes 2 ☐ No the Hospital or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 20 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Nnpatient 2 SR/Outpatient 3 DOA 27. Mainner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours and To the Funeral I cal Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 295. Signature and title of completed cause of death (Item 23a) (Type, Print) Cheverly, Md. 20185 Prince Georges Hospital

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month.

1 9 2011

32. Registra

Physicia /Medic Examin

Funeral **Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examinat must be notified at once.

Baltimore, Maryland 21215-0036 Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

State Registrar

State Registrar			Certi	ficate of	Death			Reg. No	0		243	3
1. Decedent's Name (First, Middle, Las	it)								Y	ear	3. Time o	f Death
JERRY LEE	EVANS						July	18,			9:55	A
a. Facility Name (If not institution, give	street and number)		4	b. City, Town,	or Location	of Death		4c.	County of	Death		
Topic The property The propert												
Topic Topi												
457-68-1534	7	'3	Yrs.				12/05/	1937	Įv	lary.	Land	
		10c City Town	n or Locat	ion				_		10	Od. Inside C	ity Lim
	t	100, 011, 1011			.d						1 □Yes	2 🔀
Oe. Street and Number				10f. Zip Code				10g. Citi	zen of Wha	at Coun	try?	
4600 Shank Lane				2	1817				U.S.	Α.		
11. Marital Status		ver in U.S.	13. Wa	s Decedent of	Hispanic O	rigin? (Spe	ecify Yes or No	0-	14. Race -	America		
	1 X Yes 2 □ N If Yes, Give		_				ritoan, oto.)					
			Deceder	it'e Heual Occi	nation			16h Kir	nd of Busin	nace/Inc	luetry	
(Specify only highest gra	de completed)	10a.	(Give kin	d of work done	durina mo:	st of workir	ng	IOD. KI	id of Dusii	1035/1110	iusti y	
	College (1-4or 5-	⁺⁾ ₩a	_		,0)				Sea	foo	٦	
					18. Moth	er's Name	(First, Middle	. Maiden			<u> </u>	
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	Removal from State									•	wn, State	
		Cremat	ory o	of Delm	arva	07/19	7/2011	De.	lmar,	DE		
Lobert 101	01/		Bra	adshaw	& Son	s Fun	eral H	iome .	~ 24	047		
		the death Dou							MD ZI	81 <i>T</i>	Approxima	
shock, or heart fallure. List only	one carse on each lin	ie.	not emer	ine mode or dy	mg, oden d	o our dido c	or reopiratory .	arroon			Interval Be	etweer
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resulting in death)	Due to (or as a	a consequence	of):									
Sequentially list conditions,	b									_		
if any, leading to immediate	Due to (or as a	a consequence	01):									
that initiated events	C		-6.									
obdaining in abduity addition	Due to (or as a	a consequence	oi):									
	_d									+		
IF FFMALE:												
23b. Was decedent pregnant			n 3□E	ctopic pregnar	псу			13			-	Year
1 ☐ Yes 2 ☐ No	4 Pregnant at								WOTE	•	Jay	IUal
·							1					
	•	ut not resulting in	n the unde	erlying cause g	iven in Part	l.	23e. Did			ute to th	ne cause of	death
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	Hyperter	YSTON							24b. We	ere auto	psy findings	s avail
	V. J.Y-1						perf	ormed?	de	ath?		cause
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examiner?	Hospital:			0.00	t							
	1 L Inpatie		<u> </u>	3 DOA	4 L N						(y)	
1 Natural 5 ☐ Pending	(Month, Day	v, Year) 200.) We	ork?		zou. Describe	now injur	y occurred	1		
Z D Accident		A					006 1 **	(04-	-1 A1 - 1		d Davids N	m h
- determined	28e. Place of inju	ıry - At home, fa c. <i>(Specify)</i>	rm, street	, ractory, office						or Hura	u Houte Nu	m <i>oer</i> ,
	11/9											
(Check only 2 Medical Exam	niner: On the basis of	examination ar										(s)
				29c. Licer	nse number			29d. Da	te signed ((Month,	Day, Year)	
· <	M+											
0. Name and address of person who	completed cause of de	eath (Item 23a)	(Type, Pri	int)								
		, ,			(1-a-	efte:	1d .m	2101	7			
1. Date filed (Ivioritri, Day, rear)	32. Registra	ar's Signature	<u> </u>	тдимау		rarte	IU PIL	- 4101	+			
JUL 19	2011 12_	ma A		ald								
	port	7	17									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ϊ5 2ÖÏ1 Temple Lacey Freeman 07 4:45 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ceci1 Elkton Care and Rehabilitation E1kton 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕱 M 2 🗆 F Months Days Hours Min. (Month, Day, Year) 04/15/1934 Director 218-32-5925 MD Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location Director 1 Yes 2 X No MD Ceci1 E1kton 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 39-A Starling Lane 21921 death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 Yes 2 X No Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16h Kind of Business Industry (Give kind of work done during most of working I Hygiene. life. DO NOT use retired Elementary/Seconday (0-12) College (1-4 or 5+) Plumber Plumbing should be filed with and Mental Hygien 7 is marked other th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marker any injury or other fraumatic. John Wesley Freeman Dorothy Lucille Haupt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 39 Cynthia Pearman - daughter -A Starling Lane, Elkton, MD 21921 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Kemblesville Meth. Cem. 07/20/11 | Kemblesville, PA 22. Name and Address of Facility R.T. Foard Funeral Home, PA 259 E. Main Street, Elkton, MD 21921 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ cell CONCINOMA disease or condition Medical resulting in death) Examiner NEMIA Sequentially list conditions Examine If any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events uppen Explainity Deep VENOUS and -tran resulting in death) Last Due to (or as a consequence of) physician a s the burial-TOROM BOSIS Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 attending philor use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Fregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day 1 ☐ Yes 2 ☐ No 9 ☐ Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy certificate ha perforn death? 2 🗌 No 1 Yes Yes 25. Was case referred to medical a er death. **Director:** Affer this certific Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 X No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide within 24 hours a er

To the Funeral Dire

completed filled in b City or Town, State) Medical 1 😾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 1. N. Nonge 12.

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NARMANA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

V- PULA

32. Registrar's

Signati

146 A E. MGH

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ELKTON

21921

	ľ	1 - State Registrar 1. Decedent's Name (First, Middle, Last)	State of Ma	•	Certifica				Reg. No	2011	24315	
Physicia			Hoben					2. Date of D Month O 7	eath Da 17	ay Year 2011	3. Time of Death 4 = 22A	
Medic Examin		Ronald M. 4a. Facility Name (if not institution, give st			4b. City	y, Town, or	Location of Death		+/	c. County of Deat		
		Washington Adventist Hospital					Park			Montgor	mery	
Funeral Director		5. Social Security Number 6. Sex 1X	7. Age	(In yrs. last birthd	Months	er 1 Year Days	If Under 24 Hrs. Hours Min.	(Month, D		Cor	thplace (State or Foreign untry)	
oor te	7	Usual Residence of Decedent 10a, State 10b. County		10c, City, Town o	r Location		·	,			10d. Inside City Limits	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ecto	DC		Washin		DC					1 🎇 Yes 2 □ No	
	II Dir	10e. Street and Number				ip Code			10g. C	itizen of What Co	untry?	
n with ns 23a must I	Funeral Director	3700 North Cap			L.	0011			Ь,	nada		
's after death ral", or iterr Examiner n		11. Marital Status 1 ☐ Never Married 2 ☐ Married	2. Was Decedent E Armed Forces? 1X Yes 2		13. Was Dece If Yes, spe	edent of His ecify Cubar	spanic Origin? (Sp n, Mexican, Puert	pecify Yes or No o Rican, etc.)	-	14. Race - Ame Black, White		
	Completed by	3 ☑ Widowed 4 □ Divorced	If Yes, Give Year or Dates.	NO	1 🗌 Yes	2 X] No	Specify:			Specify: Wh	ite	
"natu "natu edical	plet	15. Decedent's Edu (Specify only highest grad		16a. D	ecedent's Us	ual Occupa ork done di	ation uring most of wor	king	16b. F	Kind of Business	Industry	
ithin / ene. • than • the Me	Com	Elementary/Seconday (0-12)	College (1-4 or 5	+)	e.DONOTus trepr	,	r		R€	estaura	nt	
II Hygi other vent, 1	BB	17. Father's Name (First, Middle, Last)	<u> </u>	1171	crepr		18. Mother's Nar			Surname)		
Id be Menta arked atic e	욘	Lloyd Hoben					Ruth R					
shou hand 7 is m traum		19a. Informant's Name/Relationship (Type		19b. N	Mailing Addres	ss (Street a	nd Number or Ru	ral Route Numb	er, City o St.Jo	r Town, State, Zip ohn New B	ocodeE2K1Y5 BrunswickC	
and Healt tem 2		Ronald Hoben, J 20a. Method of Disposition	r- son	20b. Place of D	isposition (Na	ame of	<u> </u>	Date	_	ocation - City or		
Jage 1		1 ☐ Burial 2 🛣 Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	temoval from State	cemetery, Chesar	crematory`or oeake	other place	07/	19/11	1	tsvill		
Departir Departir Importa any inju		21. Signature of Funeral Sorvice Licensee	1 01	•	-	and Address	s of Facility Ph	nilip I) , R	inaldi	Funeralsy ng MD2091	
20 E # 9		Manage	Just	in						er Spri		
		23a. Fart 1. Enter the disease of compli- shock, or heart failure. List only one Immediate Cause (Final	cause on each line							_ , _	Approximate Interval Between Onset and Death	
hysician/ Medical		disease or condition resulting in death)	ACUTU Due to (or as a	BAC consequence of):	TERI	HL	END	OCAK	DI.	715		
Examiner	L	Sequentially list conditions, b	METE	ASTAT	TICE	AR	CINON	PAOF	BL	ADDEC		
ed ssit	xamine	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	ACUT	consequence of):								
axecuted in and ial-transit	ш	resulting in death) Last Due to (or as a consequence or):										
within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician of completed filled in by the funeral director, page 2 should be detached for use as the burial.	Physician/Medical		END	STAGE	RE	NAL	- D/S	SEAS	6		<u> </u>	
ding p	/Me	IF FEMALE 23b. Was decedent pregnant 23	3c. If yes, outcome o	of pregnancy						23d. Date of de	livon	
e atten d for u	icia	1 🗆 Yes 2 🗆 No	3c. If yes, outcome of 1 Live Birth 3 Pregnant at	2 Petal death time of death	3 Ectopic 5 Other (s		y			Month	Day Year	
lt trie t	Phys	g Unknown	9 ☐ Unknown Itributing to death but not resulting in the underlying cause given in Part I.				1					
signec	d by	rartii. Other significant conditions con	induling to death be	at not resulting in t	ne undenying	g cause give	en m Parti.				the cause of death?	
peen	Completed							24a. Was		24b. Were au	topsy findings available	
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ertifica ctor, p	Be C	25. Was case referred to medical examiner?				26. Pla	ce of Death (Che		2 23 IN	ioj i la res	S Z A NO	
this ce al dire	မ	1 ☐ Yes 2 No		nt 2 ER/Outp			4 U Nursing F			6 ☐ Other (Spec	ify)	
th. : After	cate	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of injury (Month, Day, Year) inju				f 28c. Injury at 28d. Describ work? M 1 ☐ Yes 2 ☐ No			e how injury occurred			
er dea rector by the	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	γ - At home, farm, street, factory, office 28			28f. Location (Street and Number or Rural Route Number, City or Town, State)						
urs aft ral Dir lled in												
24 holes	Medical		er: On the basis of ex	amination and/or in	vestigation, ir	n my opinior	n, death occurred	at the time, date	and place	e, and due to the	cause(s) and manner state	
within To the compl	Σ	29b. Signature and title of certifier 29c. License number						29d. Date signed (Month, Day, Year)				
		Chandresekler Korpati M'D MD52855						5	7-17-2011			
5		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chandra S. Korapati, M.D. 7207 B Hanover Pkwy Greenbelt, MD 20770										
Stat	e.	31. Date filed (Month, Day, Year)				ianov	er Pkw	y Gree	npe.	IT, MD	20770	
Registra		111 1 9 2011	mana &	's Signature								

State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 24316 Reg. No. 0 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year Regina 235 JUL, 2011 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Dorchester AMBRIDGE CJENELA1 HOSPITAL DORCHESTER If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03-09-1929 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Delaware 1 □ M 2 🕱 F 82 207-26-6915 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 XYes 2 No Hurlock Dorchester 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 303 Nealson St., 21643 P.O.Box 434 12. Was Decedent Ever in U.S. Armed Forces? 1 __Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2 🕱 No Specify: 3 Widowed 4 □ Divorced Black 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Upholstery upholstering 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Nettie Cannon Lindsay Plummer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21643 19a. Informant's Name/Relationship (Type, Print) P.O.Box434, Hurlock, Md. Reginald Hughes / Son 303 Nealson St., 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Eastern Shore VA. 07-15-11 Hurlock, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funer LS: vice License 22. Name and Address of Facility Bennie Smith Funeral Home 516 S.Main St., Hurlock, Md. 21643 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) END STAGE CON GESTIVE HEART FAILURE Due to (or as a consequence of): STAGE PENIAL

Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit Division of Vital Records, P.O. Box 68760, physician signed by t within 24 hours after death

To the Funeral Director:

completely filled in by the f

Physician

/Medical

Examiner

Funeral

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d other than "natural", or items 23a or 28a-f showevent, the Medical Experiment must be notified at

other traumatic

item 27

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Pages nent of I permit. Pages Department of Important: If it any injury or o once.

the Maryland

Baltimore, Maryland 21215-0036

REGINA

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Cause (Disease or injury that initiated events c. HYPOTEN >1017									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown Part II. Other significant conditions co	23d. Date of delivery Month Day Year									
Part II. Other significant conditions co	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did toba									
				24a. Was an autopsy performed 1 □ Yes 2. □						
25. Was case referred to medical	26. Place of Death (Check only one)									
	Hospital: 1 Inpatient 2 □	ER/Outpatient 3 □	Home 5 Residence	idence 6 ☐ Other (Specify)						
27, Manper of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how it						
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, street, fact	ory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
1 Yes 2 No 27, Manner of Death 1 Natural 2 Accident 5 Pending investigation 3 Suicide 6 Could not be determined 29a. Certifier (Check only one) 29b. Signature and title of certifier.	/sician: To the best of my kno iner: On the basis of examinated and manner stated.	owledge, death occurration and/or investigat	ed at the time, date and place ion, in my opinion, death occ	ce, and due to the caus curred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)					
29b. Signature and title of certifier	1.5	29c. License number D 00674		9d. Date signed (Month, Day, Year) 7/9//1						
20 Name and address of person who a	completed cause of death (Ite	m 23a) /Type Print)								

DHMH 17 Rev 1/2001

State

Registrar

5

300 Byran St. Cambridge, Md. 21613

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JUL 13 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Registrat, TCHD, 7/8/11 pha 2431 Certificate of Death Amend 19b 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician/ ALBERT JOSEPH HANEY 2011 9:45 PM July Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Talbot Easton The Pines Genesis HealthCare -7. Age (In vrs. last birthdav If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** 1 🛛 M 2 🗆 F Months Days Hours 03/M9/18/-D1/9/335 136-28-5496 76 NJ **Director** Usual Residence of Deceden or 28a-f show 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 X No CORDOVA MD TALBOT 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 21625 IISA 10816 LEWISTOWN RD · death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ō þ 1 Never Married 2 X Married Albert Haney Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE "natural", 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filled within 7 Department of Health and Mental Hygiene. Important If item 27 is marked other than any injury or other trainment. $\begin{array}{c} \text{Elementary/Seconday (0-12)} \\ 12 \end{array}$ College (1-4 or 5+) **TEACHER** COUNTY GOVERNMENT Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) P JOHN JAMES HANEY GENEVIEVE WAGNER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10816 LEWISTOWN RD CORDOVA MD 21625 AMELIA BANCO HANEY (WIFE) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 07-09-11 ST. MARY'S TRENTON 4 Donation 5 Other (Specify) NJ21. Signature of Funeral Service Licenses FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON MD 21601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ erebrovasc disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner HYPERTENSI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed CORONARY ARTER DISTASE ending physician and use as the burial-tran Due to (or as a consequence of) Physician/Medical Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown for Month Dav Year Pregnant at time of death the P.O. signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an this certificate has ball director, page 2 sl performed' 2 No Yes 2 No 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 🗌 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending injury work?
1 Yes 2 No within 24 hours after death.

To the Funeral Director: Aft completed filled in by the fur 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

10+VA

DHMH 17 Rev 7/2009

Registrar

State

Hospital

Medical

29a. Certifier

only one

SHIRENE

29b. Signature and title of certifier

JUL 07

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

410

Registrar's Signature

BENNETT

Durnmanns

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

R163758

Easton

mo

29d. Date signed (Month, Day, Year)

21601

29c. License number

Lane

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 24318 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 13^{Day} July July 20¶1 Francis Kenneth Harvey 2:26 p. M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Dorchester 16 Algonquin Road Cambridge 5. Social Security Number If Under 1 Year If Under 24 Hrs Months Days Hours Min. **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 🔀 M 2 🗆 F (Month, Day, Year) 0V • 18, 1934 **Director** 215-32-5745 76 Nov. Maryland Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location Medical Examiner must be notified at 10d. Inside City Limits Director MD Dorchester Cambridge 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 16 Algonquin Road 21613 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black, White etc. "natural", or 1 Never Married 2 Married and 2 should be filed within 72 hours after Health and Mental Hygiene. Completed by 1 X Yes 2 No Maryland 21215-0036 white 1 Yes 2 X No Specify: If Yes, Give Year or Dates 1953 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) newspaper the advertising Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Hugh Harvey, Sr. Charlene Long 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlene H. Friend 3321 Kreitler Road, Forest Hill, MD sister other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Crematory of Delmarva permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20c. Location - City or Town, State 1 🗌 Burial 2 🗵 Cremation 3 🗆 Removal from State 7/15/11 Delmar, DE 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Thomas Funeral Home P.A. Cambridge, MD 21613 700 Locust St., 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician atherosclerotic Vascular Coronary disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** perlipidemia if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Year Month Pregnant at time of death Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☑ Wo Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No Investigation Could not be Accident 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State, 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated deputy 29c. License number 29d. Date signed (Month, Day, Year) medical 40120 examine Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Registrar's Signature

18

500 Anderby Hall Ld, Loyal Oak, Md 21662

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 20 Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 12 2011 **Physician** July 9:38 p. M Helen M. Hartline /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Somerset Alice B. Tawes Nursing Home Crisfield 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 M 2 W 84 unknown Director 222-12-0347 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County f show If than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Crisfield Somerset Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21817 USA 201 Hall Highway Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2X No Specify 2 3 X Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unknown unknown unknown 12 should be filed whand Mental Hygies Is marked other to 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be ment of Health and Menta ant: If Item 27 is marked unknown unknown ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 909 Progressive Circle, Ste. 100, Salisbury, MD21804 Donna Blackwell p.r. injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or Crematory of Delmarva 7/13/11 Delmar, DE 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SCVD **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or highry that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) P.O. been signed by the should be detached 9□Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ DEMENTIA AL2HEIMERS 2/2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has briector, page 2 s perform To the Hospital or Attending Physician: 25. Was case referred to medical funeral director, 26. Place of Death Check onl one Medical Certification: To Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 27. Manner of Death 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident after death filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier A8098

Registrar

DHMH 17 Rev 1/2001

State

201 Hall Hylway, Cristical moz81)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Vyay

JUL 15 201

31. Date filed (Month, Day, Year)

Kaum bunathan

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Mar		oartment of H e <i>rtificate of D</i>			Reg. No.		24320	
	Physicia		Decedent's Name (First, Middle, Last) Lizabeth An	n	2. Date of Month July			 2011	3. Time of Death 2240 PM		
	Medic Examin		4a. Facility Name (if not institution, give	4b. City, Town, or I	4b. City, Town, or Location of Death			22 2011 2240 PM 4c. County of Death				
/	Funeral		210 Mike Drive 5. Social Security Number 6. Se	x 7. Age (lr.	Elkton If Under 1 Year			Cecil 9. Bit		place (State or Foreign		
ı	Director		222-32-9701	⊔м 2 🗓 F 46	Yrs.	Months Days	s Hours Min. July 2		o, 1964		ryland	
	and show	o.	Usual Residence of Decedent 10a. State 10b. County	10	Oc. City, Town or L	ocation				1	0d. Inside City Limits	
J.SO.	Maryl 28a-f notifie)irec	Maryland Cecil		E1ktor						1 X Yes 2 No	
	vith the 23a or st be r	Funeral Director	10e. Street and Number 210 Mike Drive			10f. Zip Code 21921			10g. Citizen of	What Coun ted S		
	death v items ier mu		11. Marital Status	12. Was Decedent Ever	in U.S. 13	. Was Decedent of His If Yes, specify Cuban	panic Origin? (Sp. Mexican, Puerto	ecify Yes or No-	14. Rac	e - Americ	an Indian,	
	after or al", or Examin	d by	1 Never Married 2 🔀 Married 3 Nidowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.		1 ☐ Yes 2 🗓 No		riioari, oto.,		ck, White, e " Whit		
0500-c	2 hours "natur edical I	Completed	15. Decedent's Ed (Specify only highest gra	lucation	16a. Dec	cedent's Usual Occupation ve kind of work done during most of working			16b. Kind of Business Industry			
7	ithin 7; iene. r than the Me	Som	Elementary/Seconday (0-12)	College (1-4 or 5+)	life.	DO NOT use retired) omemaker			In I	Her O	wn Home	
and	filed v tal Hyg d othe event,	To Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam	,	Maiden Surnam			
7	ould be nd Men marke imatic	-	Boyd Dean Lewis 19a. Informant's Name/Relationship (Ty,	iling Address (Street as	Doris Ann Phillips t and Number or Rural Route Number, City or Town, State, Zip Code)							
, <u>N</u>	nd 2 sh salth ar n 27 is er trau	l.	Chantel L. Johnson		- 1	Mike Driv			21921	state, 21p C		
ore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants if time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 X Burial 2 Cremation 3	Removal from State	20b. Place of Disp cemetery cre Immacula	position (Name of ematory or other place	July	^{Date} 26,	20c. Location			
Dallimor	mit. Pa partme portani / injury		4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service License	<u> </u>	Concepti	on Cemeter 22. Name and Address	Δ	cks Hom	Cher e for Fu	rry H unera	ill, MD ls, P.A.	
22. Name and Address of Facility Hicks Home for 103 W. Stockton Street, Elkt										n, MD 21921		
	hysician/		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Conset and Death									
	Medical Examiner		disease or condition resulting in death) a. Due to it as a consequence of):									
		Je.	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):							-		
	outed nd ransit	kamir	cause. Enter Underlying Cause (Disease or iinjury that initiated events					-	1			
	cate be executed physician and the burial-transit	edical Examiner	resulting in death) Last	Due to (or as a co								
	ifficate ng phys as the		IF FEMALE:	d								
Ď Y	ath certifica attending p	Physician/N	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p 1 ☐ Live Birth 2 ☐ 4 ☐ Pregnant at tin	Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)				ite of delive	ery Day Year	
<u>.</u>	that the decreed by the a detached	hysi	1 Yes 2 No 9 Unknown 9 Unknown									
	S D Q	þ	Part II. Other significant conditions co	ntributing to death but n	not resulting in the	underlying cause give	en in Part I.		obacco use cont Yes 2 No	_	e cause of death?	
colds,	v require s been si should	Completed	24a. Was an 24i								b. Were autopsy findings available	
ָ ב ב	The law cate has page 2 :	Com						autop perfo 1 □ Yes	rmed?	prior to cor death? 1 🔲 Yes	mpletion of cause of 2 No	
	ysician: The nis certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:	. □ . □ . □ . □	Other	ce of Death (Chec					
5	ding Phy h. After this funeral d	ite: To	1 inpatient 2 ER/Outpatient 3 DOA						lome 5 Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred			
	death.	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	M 1 🗆 Y	es 2 □ No	28f. Location (Street and Number or Rural Route			Pouto Number			
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	io the Hospital or Attending within 24 hours after death. To the Funeral Director: Aft completed filled in by the fun	edical	(Check 2 Medical Examir	ician: To the best of my	ination and/or inve	estigation, in my opinion	, death occurred a	t the time, date a	nd place, and du	e to the cau	use(s) and manner stated.	
:	Io the within To the compl	Σ	only one) 3 U Certifying Nurse 29b. Signature and title of certifier	e Practioner: To the bes	t of my knowledge	29c. License			29d. Date signer			
	100		· oulle	ridon	MD	De	161+7		+-2	6-11		
	20		30. Name and address of person who co			mors	Run 9	RD, f	Da Hi	> 9	1221	
	Stat Registra		31. Date filed (Month, Day, Year)	32. Registrar's	Signature							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar 24321 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 201 Physician/ Month 10:50 PM Evelyn Mae Johnson July 15 Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Sacred Heart Home Hyattsville Social Security Number If Under 1 Year If Under 24 Hrs. 7, Age (In yrs. last birthday) 8. Date of Birth (Month, Day 9. Birthplace (State or Foreign **Funeral** Months Hours 1 □ M 2 🖾 F Min. 471-01-3865 100 Director Yrs 910 Hibbing, Minnesota August Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c, City, Town or Location with the Maryland notified at 10d. Inside City Limits Director Maryland Prince George's Hyattsville 1 🛛 Yes 2 🗌 No 10e. Street and Number ត 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral 5805 Queens Chapel Road 20782 USA items filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 No Black, White, etc. ò δ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. White "natural", Completed 3 Widowed 4 Divorced Specify: Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 1 any injury or other traumatic event, the Me any injury or other traumatic event, the Me once. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Government Stenographer Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 James Johnson Celia McNamara 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Howard F. Johnson / Brother 8609 Cunningham Drive, Berwyn Heights, MD 20740 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 7/21/2011 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery Silver Spring, Maryland Signature of Funeral Service Licenses 22. Name and Address of Facility 4739 Baltimore Avenue de Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Atherosclerotic Cardiovascular Disease disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 X No 4 ☐ Pregnant at time of death 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Dyslipidemia 24a. Was an autopsy performed? Dementia 2 🛛 No 1 Yes 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🔀 No Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending work Acciue.
Suicide 2 🗌 No Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination allows investigation, it my opinion, year occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier nowde D43121 7/18/2011

Registrar
DHMH 17 Rev 7/2009

State

Nurul Amin Chowdhury, M.D., 15216 Dino Drive, Burtonsville, MD 20866

30. Name and address of person who completed cause of geath (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death KOSHY Physician/ 11:12 AM PAPPACHAN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Takoma rwith the transfer of Birth (Month, Day, You and Days Hours Min. Annil 24 Montgomery Washington Adventist Hospital Birthplace (State or Foreign Country)
 Tundia **Funeral** Year 1 🗓 M 2 🗆 F Months India 230-33-0960 69 **Director** 1942 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10c. City. Town or Location 72 hours after death with the Maryland Examiner must be notified at Director 1 Yes 2 No College Park Maryland Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 items 23a Funeral 9003 St. Andrews Place 20740 u.s.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. and Mental Hygiene. Š 1 Never Married 2 X Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: If Yes, Give Asian 3 Divorced Completed Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Typist Clerk Howard University Be 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) ဂ Mariam Kochukoshy Chacko Kochukoshy permit. Page 1 and 2 should by Department of Health and Mer Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chinnamma Pappachan Koshy/Spouse 9003 St.Andrews Place, College Park, MD 20740 20b. Place of Disposition (Name of , 20c. Location - City or Town, State Kadampanad, Kerola, 20a. Method of Disposition St. Thomas Orthodox Cathedral Cemetery 1

Burial 2

Cremation 3

Removal from State 07/22/2011 4 □ Donation 5 🕱 Other (Specify) Entombment India 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 1232 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ATHEROSCEROTIC DISEASE Immediate Cause (Final HEART Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine due to (or as a nonsequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events and -transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last physician the burial burial Physician/Medical P.O. Box 68760 attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death signed by the a 2 🗌 No g Unknown 9 Unknown Part II. **Other significant condition**s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? this certificate 2 🗋 No 1 Yes Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?

1 Yes Hospital Other: 2 No 1 Inpatient 2 ER/Outpatient 3 I DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury 28b. Time of 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural iniun 5 Pending ☐ Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State, Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number DO055918

State Registrar

O

WHOKEINGTON

Registrar's Signature

ADVENTIST HOSPITAL; TAKOMA PARK, MD

Name and address of person who completed cause of death (Item 23a) (Type, Print)

MT

SWITTES

Year

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 24323 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year Karen Marie Leaman 8:10 AM July. 17 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 926 Topmast Way Annapolis Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday 8. Date of Birth
(Month, Day, Yea
July 2, 1 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2 🖾 F 220-70-9464 56 Washington, DC Director Ĩ955 Usual Residence of Decedent 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f Maryland Anne Arundel Annapolis 1 X Yes 2 No 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? pe Funeral ms 23a must be 926 21401 Topmast Way USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ō ģ 1 Never Married 2 Married 2 X No ☐ Yes Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify. White Specify: "natural" Completed 3 Divorced 4 Divorced the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 I Hygiene. College (1-4 or 5+) Capital Cadillac Service Administrator of Health and Mental Hygie If Item 27 is marked other Ir other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Joseph Richard Mascolino Rose Marie Vendemia permit. Page 1 and 2 should be Department of Health and Men-Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Meredith M. Leaman / Husband 926 Topmast Way, Annapolis, MD 21401 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Metropolitan Crematory 7/22/2011 Alexandria, Virginia 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the dilease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner rellan Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a conse-Exami the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Box 68760 as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnar 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 month Month Pregnant at time of death Dav Year signed by the a d be detached f 9 Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>გ</u> Division of Vital Records, 1 Tes 2 To 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has performed Yes 2 certificate 2 🗌 No 1 Yes nin 24 hours after death.

the Funeral Director: After this certifical plated filled in by the funeral director, in the funeral director, in the funeral director, in the funeral director, in the funeral director, in the f 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 1 No ဂ္ဂ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar

DHMH 17 Rev 7/2009

State

29b. Signature and title of certifier

9 2011

31. Date filed (Month

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MO

2003

32. Registrar's Signature

Medica

3306

Parkway

29d. Date signed (Month, Day, Year)

Ste 210 Annapolis

2149

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Amend #29d, 7-19-2011, per Dreathicate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 201 Tear Margaret Lenderman 13. 12:00 Sarah Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hebrew Home of Greater Washington Montgomery Rockville If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 1 M 2 X F Months Country) 578-01-4371 Director 93 D.C. 1917 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified ** once. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director MD 1 Yes 2X No Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6121 Montrose Road 20852 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian, Was Decedent Ever Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. Completed by 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: SpecifWhite 3

Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ James S. Watts Matilda Gallagher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen Liegerot/Daughter 130 Dorer Drive, Auburn, CA 95603 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town. State July 19 2011 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) John's Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, MD 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, 21. Signature of Funeral Service Licensee 11101503 MD 20901 Page 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ NEYMONIA disease or condition Medical resulting in death) **Examiner** ORGANISMS E N Securitally ist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) To the Hospital or Attending Physician. The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending house and ending physician and use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 5 Other (specify) Year Pregnant at time of death Month Day been signed by the a should be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 1 🗌 Yes completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) July 13,/2011 00 18084 cenowi) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dineshbhai Patel, MD 6121 Montrose Road, Rockville, MD 20852 31. Date filed (Month, Par Year) 9 2011 Pegistrar's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 \(\int \) 24325 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 4504 WINDY HILL ROAD TRAPPE TALBOT Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 □ M 2 🕱 F Months Days Hours Min 9/4/1931 **Director** 79 MARYLAND 220-28-1346 Usual Residence of Decedent nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene.

ortant, If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2X No MD TALBOT TRAPPE, MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4504 WINDY HILL ROAD 21673 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 X No Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: WHITE Specify. Completed 3 X Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) MICRO FILM CLERK 12 MEMORIAL HOSPITAL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ JOHN T. DOBSON ROSALINE MOORE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DORIS EMILY ALTENBURG (DAUGHTER) 322 CHELTEN PARKWAY, CHERRY HILL, NJ 08034 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or otl Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) OXFORD CEMETERY 7/13/2011 OXFORD, MARYLAND 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. MER 200 SOUTH HARRISON STREET, EASTON, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ordia Physician O disease or condition Medical resulting in death) a consequence of) Due to Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Exami Hospital or Attending Physician: The law requires that the death certificate be executed car attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death Month Year signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 24 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 autopsy performe 2 🗌 No 1 🗌 Yes Yes 25. Was case referred to mee cal Be 26. Place of Death (Check only one) examiner? Hospital: Other: မှ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann F Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural (Month, Day, Year) 5 Pending Accident 2 🗌 No 1 Tes within 24 hours after death

To the Funeral Director: / Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b, Signature and title o 30. Name and add ess of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Mo

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Registrar's Signati

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	neral ector		218-34-1109	7. Age (In yrs. 73	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month Day 2/20/1	938	9. Birthp Count	lace (State or Foreign try) PA
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10re, Maryland 21215-0036 ge 1 and 2 should be filed within 72 hours after death with the Maryland art of Health and Mertall Hygiene. The firm 27 is marked other than "matural" or items 29a or 29a-4 shows	Examine	þ	1 ☐ Never Married 2 🖾 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 XNo If Yes, Give Year or Dates,		Yes, specify Cuba		Rican, etc.)		k, White, e	
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	1		30. Name and address of person who con	poleted cause of death (Iten	n 23a) (Type, Pr	int)		2 2		011	1 0==
10	0		31. Date of onth, Day, Year)	Sksoupe	<u> </u>	N 22	23 W	Man	34.	> 1 (C	by, m
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 24327 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 16 Month 07 **2**011 9:45 P M Nicholas G. Lempesis Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Cecil Elkton Care and Rehabilitation Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 D F Months Days Hours Min. 01711V/1941 PA Director 212-40-6601 70 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No MD Cecil E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21921 USA 245 East Main Street 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No Black, White, etc. 1 🛮 Never Married 2 🗆 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha Self Employed Mobile Homes Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ George Nicholas Lempesis Ada Bierkampe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s if Health a item 27 i 204 Cara Cove Road, North East, MD 21901 Hazelanne Z. Schmauder - POA injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Rising Sun, MD .Foard Funeral Home, PA 21. Signature of Funeral Service Li 22. Name and Address of Facility R.T. Foard Funeral Home, P.A. Main Street, Elkton, MD 21921 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): sician and burial-transit Exam Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): inding physician ause as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 M Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of reun 24a. Was an autopsy performe death? 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? မ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work within 24 hours after death.

To the Funeral Director: A 1 🗀 Yes 2 🗌 No Accident Investigation filled in by the Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🔾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and tite of certifier

Registrar DHMH 17 Rev 7/2009

State

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KHANMD

32. Registrar's Signature

SHAHNAWAZ

31. Date filed (Month, Day, Yea

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29d. Date signed (Month,

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 24328 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 07 3. Time of Death Physician/ 2011 Esther G. Litzenberg 3:40 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Calvert Manor Healthcare Center Rising Sun Ceci1 If Under 1 Year If Under 24 Hrs Months Days Hours Min. Funeral 5. Social Security Number 7. Age (In yrs, last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🕱 F Month Day, Year) 15 Director 215-32-8498 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Ceci1 MD E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 105 Walnut Lane 21921 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces' Black White etc. Completed by 1 Never Married 2 Married ☐ Yes 2 🛛 No Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 X No Specify: White 3X Widowed 4 □ Divorced Year or Dates Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Herbert C. Garrett Ruth Moss 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Walnut Lane, Robert Litzenberg Jr. - son 105 Elkton, MD 21921 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of IImportant: If ite
any injury or ot Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) 07/25/2011 Cemetery Elkton, MD 21. Signature of Funeral Se Licensee 22. Name and Address of Facility R.T.Foard Funeral Home, PA 259 E. Main Street, Elkton, MD 21921 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one ca Interval Between Immediate Cause (Final disease or condition resulting in death) of Alzheimer's Physician/ ementic Medical Due to (or as a consequence of) Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of, To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month signed by the aid be detached f significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pothyroidism Completed 1 Yes 2 No 3 Probably 4 Unknown peen ertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has I completed filled in by the funeral director, page 2 s performed: 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 Other: 1 Tes 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accider 5 Pending 1 Yes 2 No Accident Investigation Suicide ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifig 29d. Date signed (Month, Day, Year) 041914 NO02832 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

101 Colonial

32. Registrar's Signature

Sun

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 24329 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 5:49 PM Gilbert Lane Minor 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** County of Death Regional Hospital Prince George's Laurel Laure Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Greenville, Texas 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth Days 1 🔀 M 2 🗆 F Mir (Month, Day, Hours 464-42-1889 79 Director Usual Residence of Decedent Hygiene. other than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince George's Laure1 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14914 Ashford Court 20707 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1952-1956 1 ☐ Yes 2 X No Specify: 3 Divorced 4 Divorced Specify: **Black** Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) District Photo Printer Developer 3 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Van Roberson Helen O. Lancaster 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14914 Ashford Court, Laurel, MD 20707 Estelle M. Minor / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 7/25/2011 4 ☐ Donation 5 ☐ Other (Specify) Crownsville, Maryland Maryland Veterans Cemetery Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 RAY Rogers 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Infarction Physician Acute Myocardial Medical resulting in death) Due to (or as a consequence of) Examine Sequentially list conditions, if any leading to immediate Examine Due to or as a consequence of cause. Enter Underlying or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury ate has been signed by the attending physician and page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) Day Year 4 Pregnant 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has I completed filled in by the funeral director, page 2 s autopsy 25. Was case referred to medical examiner?
1 ☐ Yes 2 ▼No Be 26. Place of Death (Check only one) Other: မ 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural injury 5 Pending Accident Suicide Investigation

State

To the Hospital

Medical

29a. Certifier

(Check

only one)

29b. Signature and tit of certifier

31. Date filed (Month, Day, Year)

JUL 1 9 2011

DHMH 17 Rev 7/2009

Registrar

6 Could not be

Hammond,

determined

Certifying Nurse Practioner: To the bes

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Laurel

MD

Regional

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Ɗ 23685

Emergency

Hospital

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,

7300 Van Dusen Rd.

MD 20707

City or Town, State)

			For State Registrar	State of M	laryland	d / Depa <i>Cer</i> i	rtment of F tificate of D	lealth Death	and M		giene 2 Reg. No.	011	243	30
Ī	Physicia	n/	1. Decedent's Name (First, Middle,	•						2. Date of Dec	ath _	14 Year 1	3. Time of De	eath M
	Medic Examin	al	Margaret T. 4a. Facility Name (if not institution,				4b. City, Town, or	Location	n of Death		_	ounty of Death		IVI
			Union Hospit 5. Social Security Number		ge (In yrs. la	et hirthday)	E1kt		er 24 Hrs.	8. Date of Birl		ecil	nplace (State or F	oroign
	Funeral Director		214-22-3891	1 M 2 AF	91	Yrs.	Months Days	Hours		10/22/			PA	
	and show at	۱۵	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Loc	ation			-		П	10d. Inside City I	Limits
	Maryk 28a-f	Director	MD Ceci	1	E	1kton	_					1 🗌 Yes 2	₩ No	
	vith the 23a or st be r	ral	10e. Street and Number 14 Shiloh Dr			10f. Zip Code 21921				10g. Citizen of What Coun				
စ္တ	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Marri			If	/as Decedent of Hi Yes, specify Cuba	n, Mexic	an, Puerto F	cify Yes or No- Rican, etc.)	14	. Race - Amer Black, White	, etc.	
Ö	atural" cal Exa	3 Midowed 4 Divorced If Yes, Give Year or Dates. 15. Decedent's Education 16a, Decedent's Usual Occupation 16b, Kind of Busic												
Maryland 21215-0036	hin 72 h ne. than "n e Medi	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Busin									industry		
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ylar	should be file h and Mental I 7 is marked o raumatic eve	잍	Peter Townsley Rachel McKensie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State											
	d 2 shou alth and 27 is m r traum		Alexander T.				g Address (Street a hiloh Dr					wn, State, Zip	Code)	
Baltimore,	ge 1 and t of Heal If item or other		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation	3 ☐ Removal from State		ace of Dispos emetery, crem	sition (Name of eatory or other place	e)	D	ate	20c. Loca	tion - City or	Town, State	
altim Tim	permit. Page 1 Department of Important: If it any injury or o		4 Donation 5 Other (Specify) Arlington Cemetery 7/21/2011 Dr									Drexel Hill, PA nes & Crematory, Inc.		
ñ	permit Depar Impor any in		Nieloli D. Picolelli McCrery & Harra 3924 Concord Pk Wi											
	Thurisian/	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition UROSEPSIS											Approximate Interval Betwe Onset and Dea	
عمير	Medical Examiner		disease or condition resulting in death)	a. Due to (or as	a conseque		MOSERS	1>						
	LXammer	Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a conseque	ence of):								
	cuted ind transit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events	C								- 13		
09	be exe	dical E	resulting in death) Last	Due to (or as	a conseque	erice oi).								
9289	rtificate ing phy e as the		IF FEMALE:	00-16										
P.O. Box 687	To the Hospital or Attending Physician; The law requires that the death certificate be executed within £4 hours are death. To the Funeral Director Affer this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🎮 No 9 ☐ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 🔲 Fetal at time of d	death 3	Ectopic pregnand Other (specify)	y .			23	d. Date of deli Month	very Day Yea	ar
ds, P.O	quires that t en signed b uld be deta	ed by P	Part II. Other significant condition	ns contributing to death l	but not resu	ulting in the ur	nderlying cause giv	en in Pa	rt I.				the cause of deat	
Division of Vital Records,	The law rec cate has bee page 2 sho	Completed by	TIA							24a. Was autop perfo 1 Yes	osy rmed?	prior to c death?	opsy findings ava ompletion of caus 2 No	ilable se of
/ital	sician; s certific lirector,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🔏 No	Hospital:	siont 2 🗆 I	ER/Outpatien	Toth	er.	eath (Check			101	£.)	-
of	ng Phy fter this ineral d		27. Manner of Death 1 X Natural 5 □ Pending	28a. Date of inju	ury	28b. Time of injury	28c. Injury work	/ at		ne 5 Residente R			TY)	
ision	r Attendi er death rector A by the fi	Certificate:	2 Accident Investig 3 Suicide 6 Could r 4 Homicide determi	ot be 28e. Place of Inj	jury - At hor c. (Specify)		M 1 C	Yes 2		28f. Location (S City or Tow		lumber or Run	al Route Number,	
ā	spital or ours ar eral Dir filled in		29a. Certifier 1 \(\sum \) Certifying	Physician: To the best of			ccured at the time	date an	d place, and			manner as stat	ted.	
	the Hos the Fun the Fun	Medical	(Check 2 Medical Exonly one) 3 Certifying	aminer: On the basis of e Nurse Practioner: To the	examination	and/or investi	gation, in my opinic eath occurred at the	on, death e time, da	occurred at ate and place	the time, date a	ind place, ar	nd due to the c	ause(s) and mann	er stated.
	So o		29b. Signature and tipe of certifier	A	ND		29c. License				29d. Date 9	signed (Month	, Day, Year)	
	6		30. Name and address of person w	ho completed cause of c	death (Item	23a) (Type, P	-1A)		•	0 -				
	Sta	e	31. Date filed (Month, Day, Year)		rar's Signati	HUGU ure	STINE HE	RMA	n Hmy	SUITE	4, CHE	SAVEAK	ECITY,M	115
	Registra		JUL 1 9 201	1 Severa	1.	park	1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Day 2011 Physician/ Jeanne Manning aka Louise Jean Manning July Louise 17, 7:50 a^{M} Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Brighton Gardens-Columbia Columbia Howard . Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex 8. Date of Birth **Funeral** Country Days Min Nov. 9, 1925 1 M 2XX 034-16-4450 Director 85 Usual Residence of Decedent 28a-f show ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits death with the Maryland Director 1 Yes 2X No Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20783 9209 25th Place USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, þ 1 Never Married 2 Married ☐ Yes 2 🛣 No Yes, Give Saltimore, Maryland 21215-0036 be filed within 72 hours after 1 ☐ Yes 2 A No Specify. Specify: White "natural", Completed 3

Widowed 4 □ Divorced Year or Dates other traumatic event, the Medical Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) id Mental Hygiene. marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Telecommunications Engineer Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Majden Surname) ပ Alexander Martin Scott Ella Gertrude Moore t. Page 1 and 2 should b tment of Health and Mer rant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10412 Edgewood Avenue, Silver Spring, MD 20901 Dennis J. Manning, III/Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 8/9711 cemetery, crematory or other place) 1 DBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Arlington National Cemetery Arlington, VA 21. Signature of Funeral Service Licensee Francis Adgress Collyins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Scleroderma years disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the burial-transit Cause (Disease or linjury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year signed by the a d be detached f 2 X No g | Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertension, Chronic Kidney Disease, Debility 1 ☐ Yes 2 K No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Assisted Living Hospital 2 🔀 No ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 X Natural 5 Pending injury 1 Yes 2 No 24 hours after death.

Funeral Director: A 2 Accident
3 Suicide
4 Homicide Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined 1 Gertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 [within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) July 18, 2011 D56531

State Registrar

15

Registrar's Signature

8600 Old Snowden River Parkway, #301, Columbia, MD 21045

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Harry Li, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. N2 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Physician/ 10 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner TALBO HOSPITAL EASTON MEMORIAL 7. Age (In yrs. last birthdav) If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 D F Months Days Hours Min. (Month **Director** Mary 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director must be notified 1 Ves 2 No or 10e. Street and Number 10g. Citizen of What Country? Funeral 23a items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. Examiner o ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates "natural", Completed 3 Widowed 4 Divorced lack the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Manufac Ifth and Mental Hygie 27 is marked other r traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ McNaMara 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Rolle Number, City or Town, State, Zip Code) Marylan 2 21613 Department of Healti Important: If item 2' any injury or other t other t aroth 20c. Location - City or Town, State Method of Disposition 20b. Place of Disposition (Name of Date 1 PBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) Cambridge Cemetery 4 Donation 5 Other (Specify) ture of Funeral Service Licenses 22. Name and Address o Facility tome; HENry Washing 23a. Han 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Multiple disease or condition Medical resulting in death) a consequence of): **Examiner** nontles Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner rontes the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Dav Year signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Unknown 1 Yes peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an within 24 hours after death.

To the Funeral Director: After this certificate has I autopsy cardione Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 No ျ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident Investigation 6 🗆 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and titl 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Morte

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year,

JUL 25

32. Regis

ar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 For State Registrar 24334 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JulvPhysician/ 2011 11:50 P M Miles Nimmo Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Prince Georges Clinton Pineview Future Care 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. March 22 Virginia 1 **X** M 2 □ F 719 14 2462 89 Director Usual Residence of Decedent mit. Page 1 and 2 should be filed within 72 hours after death with the Maryland startment of Heatlih and Mental Hyglene. optimity or items 23a or 28a-f show optant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Directo 1 ☐ Yes 2X No Maryland Prince George's Fort Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 509 Hadrian Lane 20744 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? 1 V Yes 2 No If Yes, Give Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify: **Black** 3 ₩Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Tractor-Trailer Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Annie James Green Benee Nimmo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane N. Hunter (Daughter) 509 Hardrian Lane, Fort Washington, MD 20744 20a. Method of Disposition 1 ₩ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 s Department of H Important: If ite Roosevelt Memorial Park July 16, 2011 Chesapeake, Va. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria 21. Signature of Funeral Service Ferry Road, Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Exami The law requires that the death certificate be executed Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year Month Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown cate has been signated by page 2 should by Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No Physician: 25. Was case referred to medical director, 26. Place of Death (Check only one) Be 2 No Other: 1 Yes ပ 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 Natural injury

Box 68760 P.O. Records, Division of Vital

To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral

2 Accident
3 Suicide

4 Homicide

29a. Certifier (Check

Investigation 6 Could not be

determined

State Registrar

Medical

285

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

who completed cause of death (Item 23a) (Type, Print)

1 Yes

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 No

Location (Street and Number or Rural Route Number, City or Town, State)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend items 20a,22 per fh g918 8-2-11 vt.
State of Maryland Department of Health and Mental Hygiene
amend Items 20b-c, per fh, g918 8-2-11 sm

Certificate of Death for State Registrar 24335 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MA 7480 Month Physician/ JUL 201 Kimberly Lynn Rupe Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4h City Town or Location of Death Examiner Baltimore Union Memorial Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** Dct (Month 8 Day, 1963 1 🗆 M 2 🗓 F Months Days Hours Min Maryland 47 Director 212-88-7306 Usual Residence of Decedent show 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location must be notified at the Maryland Director 1 X Yes 2 No 28a-f Baltimore MD 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 21218 USA Page 1 and 2 should be filed within 72 hours after death with 2700 N. Charles St. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, ral", or iten Examiner r Armed Forces 1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🛣 No Specify: white Specify "natural", Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) disabled none unk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Shirley Ann Keister Cleveland Grover White 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 434 Pitman Place; Baltimore, Mayrland 21202 Clevia Ann White - sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot once. ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State 7-29-11 4 Donation 5 Other (Specify) In Atlantic Crematory Glen Burnie,MD 22 Name and Address of Facility State Anatomy Board Simplicity Cremation and Funeral Thomas Sign itus or Funeral Service License Ronald Waste 7090 Ridge Rd. Im Hanover MD. 21078 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between or heart failure. List only one cause on each line shock Immediate Gause (Final disease or condition resulting in death) Onset and Death Ph, sician/ tastatic Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any cause Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to lor as a conse uence of Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director After this certificate has have simple to the control of After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Month Year Pregnant at time of death 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? 1 Yes 2 No 25. Was case referred to medical the funeral director, Be 26. Place of Death (Check only one) Hospital Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 ☐ Yes 2 ☑ No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural iniury work?
1 Yes 2 No 5 Pending after death. Director: Aft 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined City or Town, State) Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one) 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) 1)0053539 Name and address of person who completed cause of death (Item 23a) (Type, Print) Parkway Baltimore, MD 21218 201 East University State AUG 0 1 201 Registrar

4a. Facility Name (if not institution, give street and number) 12417 Starlight Lane 4b. City, Town, or Location of Death Bowie	3. Time of Death
Vedical Examiner Tracy Lynn Rice July 18, 2011	1 2337 RTS
Tuneral Director 214-86-3898 1 M 2 K F 41 Yrs. Bowie Sowie S	
Director 214-86-3898 1 Months Days Hours Min. Aug 25,	
Usual Residence of Decedent	MM/DD/YYYY) 9. Birthplace (State or Foreign Country) MD
	10d. Inside City Limits
10b. County 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location	1 X Yes 2 No
MD Prince George's Bowie MD Prince George's Bowie 10c. Street and Number 10f. Zip Code 10g. Code 10	Citizen of What Country? USA
The part of the pa	14. Race - American Indian, Black, White, etc.
11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No No specify:	Specify: Black
15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NOT use retired)	6b. Kind of Business/Industry
College (1-4 or 5+)	Private
Property of the state of the st	
James E. Brooks Frances Gloriam 7 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number)	
Joseph Wells/ Brother 549 Old Stage Road, Glen Burni	ie, Maryland 21061
20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Method of Disposition 20d. Place of Disposition (Name of cemetery, crematory or other place)	0c. Location - City or Town, State
201. Frace of Disposition X Burial 2 Cremation 3 Removal from State Crematory or other place)	Clinton,Maryland s Funeral Home
14/4 Landovel Roddy Bandove	er, Maryland 20785
Physician 23a. Part I. Error the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, failure. List only one cause on each line. Butorphanol and Nortriptyline Intoxication	shock, or heart Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a. complicating dilated cardiomegaly Due to (or as a consequence of):	Boati
Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	
AMENDED 23a,pt.II,27,28a-f,per me,g918 8-3-11 s	SM .
9 a significant of the second	23d. Date of delivery
Second of the past 12 months? 1	Month Day Year
1 Yes 2 No 9 V Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobac	cco use contribute to the cause of death?
Morbid Obesity The state of the significant contributing to death but not resulting in the different plants of the significant contributing to death but not resulting in the different plants of the significant contributing to death but not resulting in the different plants of the significant contributing to death but not resulting in the different plants of the significant contributing to death but not resulting in the different plants of the significant contributing to death but not resulting in the different plants of the significant contributing to death but not resulting in the different plants of the significant contributing to death but not resulting in the different plants of the significant contributing to death but not resulting in the different plants of the significant contributing to death but not resulting in the different plants of the significant contributing to death but not resulting in the different plants of the significant contributing to death but not resulting in the different plants of the significant contributing to death but not resulting in the different plants of the significant contributing to death but not resulting in the different plants of the significant contributing to death but not resulting in the different plants of the significant contribution of t	2 No 3 Probably 4 V Unknown
Morbid Obesity Morbid Obesity Morbid Obesity Morbid Obesity 1 Yes 2 24a. Was an autopsy performed to the property of the	24b. Were autopsy findings available prior to completion of cause of
performer 1 ▼ Yes 2 [
25. Was case referred to medical examiner? 1 Ves 2 ER/Outpatient 3 DOA Other4 Nursing Home 5 Res	sidence 6 🗸 Other: Scene
The state of the s	
Natural 5 Pending Investigation Fd 7-18-11 Fd 11:15 pm 1 Yes 2 No Unknown	
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29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 25c.	s) and manner as stated.
ore) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and and manner stated. 29b. Signature and title of certifier 29c. License number 25c.	9d. Date signed (Month, Day, Year)
Quetz O.C.M.E.	July 19, 2011
30. Name and address of person who completed cause of death (Item 23a)	
Ana Rubio MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 24337 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 3011 1015 HENRY EUGENE SMITH, JR. Medical 4a. Facility Name (if not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner EASTON TALBOT MEMORIAL EASTON HOSPITAL 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Days Hours NOV. 17, 1938 1 😿 M 2 🗆 F MARYLAND 72 **Director** 214-34-8664 Usual Residence of Decedent show 10b. County th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No QUEENSTOWN QUEEN ANNE'S MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 21658 6442 MAIN STREET Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status rmed Forces?

Yes 2 No
Yes, Give 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1956–1960 1 ☐ Yes 2 👿 No Specify: Specify: 3 Widowed 4 Divorced WHITE Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) life, DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) **AUTO PARTS** AUTO PARTS STORE OWNER 11 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname **EDNA GERTRUDE ANDERSON** ပ္ HENRY EUGENE SMITH, SR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 6442 MAIN ST., QUEENSTOWN, MD 21658 SHIRLEY A. SMITH/ WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 **X** Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) EASTON, MD WOODLAWN MEMORIAL PARK 21, 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME,
408 S. LIBERTY ST., CENTREVILLE, MD 21617 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph. sician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events oalbumineam resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Day Year Yes 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 W No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No Yes 202 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes Certificate: To 2 No 1. Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Katural 5 \square Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1/24 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 🗀 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 29b. Signature and title of certifier

Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

29d. Date signed (Month, Day, Year,

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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Physicia Medic		1. Decedent's Nam	e (First, Iviladie, L	Slipper		INCE SI	11PPER,	, Jł	· · · · · · · · · · · · · · · · · · ·	2. Date of De Month	Day	ao II	3. Time of Death 3:30 AM	
Examine				EEK ROAD					Location of Deat	h		unty of Death		
Funeral Director	- 1	5. Social Security N 216-28-57	789	Sex 1 X M 2 □ F	ge (In yrs. 80	last birthday) Yrs.	If Under 1 Months	Year Days	If Under 24 Hrs Hours Min.	8. Date of Bir	1930		nplace (State or Foreign	
yland -f show ed at	ctor	Usual Residence o	10b. County			ty, Town or Lo							10d. Inside City Limits	
he Mar or 28a	Funeral Director	MD 10e. Street and Nu	QUEEN A	ANNE'S	S	TEVENS	10f. Zip (Code			10g. Citizen	Og, Citizen of What Country?		
is 23a nust be	neral	107 SHI	PPING CR	EEK ROAD				666			UNITED STATES			
be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f show ked other than "natural", or items 23a or 28a-f show ic event, the Medical Examiner must be notified at.	ρ	11. Marital Status1 Never Mar3 Widowed	ried 2 Married	If Yes, Give	No 19	51-	Was Decede If Yes, specif 1 Yes 2	y Cuba 	spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No- to Rican, etc.)		14. Race - American Indian, Black, White, etc. Specify: WHTTE		
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permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical Borce.	as l	17. Father's Name		SLIPPER,	SR.					me (First, Middle,		name)		
12 should alth and M 27 is mai r traumat		19a. Informant's N	ame/Relationship						and Number or Ru		-		Code) MD 21666	
bage 1 and tent of Hes nt: If item				☐ Removal from State	9	Place of Disp cemetery, cre	osition (Name matory or oth CEMET	e of ner plac	:e)	Date 9/2011	20c. Locat	ion - City or	Town, State	
permit. E Departm Importa any inju once.		21. Signature of Fu				Į į	2 Name and ELLOWS	Addres	s of Facility ELFENBEI CK ROAD	N & NEW	NAM FU	NERAL 21619	HOME, P.A.	
	\dashv	23a. Part 1. Enter	the disease, or co	omplications that cause y one cause on each lin	ie.	th. Do not en	ter the mode	of dyin	g, such as cardia			21012	Approximate Interval Between	
Physician/ Medical		Immediate Cause disease or conditi resulting in death)	(Final on	a	Pan		ic Cav	Cla	2				Onset and Death	
Examiner				Due to (or as	a conseq	uence of):								
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director After this certificate has been signed by the attending physicic completed filled in by the funeral director, page 2 should be detached for use as the but	by Physician/Medic	IF FEMALE: 23b. Was deceden in the past 12 1 ☐ Yes 2 9 ☐ Unknown	months? □ No	23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant 9 ☐ Unknown	2 🔲 Fet at time of	al death 3	☐ Ectopic pr ☐ Other (spe		şy		23d	. Date of deli Month	very Day Year	
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requires	Completed									1 L	Yes 2 1		obably 4 Unknown opsy findings available	
sician: The law r certificate has b irector, page 2 sl	dwo									auto		prior to death?	completion of cause of	
cian: T sertifica setor, p	Be	25. Was case refer examiner?		Hospital:					ace of Death (Che		2 121110			
g Physi er this c eral dir	e: To	1 Yes 2 27. Manner of Dea	th	1 ∐ Inpa 28a. Date of inj	ury	28b. Time o	of 28	c. Injur	4	lome 5. Resi			fy)	
tending leath. tor: Afte the fun	Certificate:	1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide	5 ☐ Pending Investigat 6 ☐ Could no	t be		injury	М		Yes 2 No					
nital or At urs after or ral Direct lled in by		4 ☐ Homicide	determine	ed 28e. Place of In building, e	tc. (Specif	5y) 				City or To	vn, State)		al Route Number,	
e Hosp 24 hor e Fune	Medical	(Check	2 🖳 Medical Exa	hysician: To the best of aminer: On the basis of lurse Practioner: To the	examinatio	on and/or inve	stigation, in m	y opinio	on, death occurred	at the time, date	and place, and	d due to the c	ause(s) and manner stated.	
To th withir To th comp	-	29b. Signature and						-	number			gned (Month		
CHIMS		30. Name and add	ress of person wh	no completed cause of	death (Itor	n 23a) (Type	Print)	V3:	2353		1414	10, 2	CII	
(1111		Diniel:	T. Konick	M.D. IJ.	5 Sa	11:++]	Drive,	Suit	e E St	Evensville	e, MD	2166	6	
Stat Registra	e r	31. Date filed (Mon	JUL 18	2011 32. Braist	rar's Signa	ature A.	base	-			,			

			1 - State of Maryland State of Maryland	d / Depa <i>Cer</i>	artment of H <i>tificate of L</i>	Health and M Death		iene eg. No. 0	11 24339
	Physicia Medic		Decedent's Name (First, Middle, Last) Robert Sherwood Spence				2. Date of Deat		Year 3. Time of Death 4:45 P M
_	Examir		4a. Facility Name (if not institution, give street and number) Casey House		4b. City, Town, or Rockvil	r Location of Death	-	4c. County o	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last 1 X M 2 F 60	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth		9. Birthplace (State or Foreign Washington, DC
	aryland a-f show fied at	Director	Usual Residence of Decedent 10a. State 10b. County 10c. City,	Town or Loc	cation				10d. Inside City Limits 1X Yes 2 □ No
	s 23a or 28s ust be notif	Funeral Dire	MD Prince George's Land 10e. Street and Number 1933 Village Green Drive	dover	10f. Zip Code 20785		1	0g. Citizen of Wh	hat Country?
920	s after death ral", or item Examiner m	ρ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates,	If	Vas Decedent of H Yes, specify Cuba	ispanic Origin? (Spe an, Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)		- American Indian, , White, etc. Black
Maryland 21215-0036	ould be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)	(Give k life. DC	lent's Usual Occup kind of work done of O NOT use retired) Courier	ation during most of worki		16b. Kind of Bus Departme	
yland 2	ld be filed w Mental Hygi arked other atic event, t	To Be	17. Father's Name (First, Middle, Last) Earnest Spence		- Courter	18. Mother's Name Ella Mae		bervices	
, Mar	nd 2 shou salth and n 27 is m er traum		19a. Informant's Name/Relationship (Type, Print) Robert S. Spence, JR. (son)	19082					
Baltimore,	permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic en once.		20a. Method of Disposition 1	od, MD					
Ra	permii Depar Impor any in		21. Signature of Funda Service Licensee	100		^{ss of Facility} For ensburg			al Home , MD 20722
	Physician/ Medical Examiner		23a, Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause final disease or condition resulting in death) Ridney Fai Due to (or as a conseque	lure	r the mode of dyin	g, such as cardiac o	r respiratory arre	st,	Approximate Interval Between Onset and Death
	icate be executed physician and s the burial-transit	l Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last b. Due to (or as a conseque c. Due to (or						
2/00/	ficate be g physici as the bu	/ledical	d						
. BOX 68	To the hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours fart death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnant 1 ☐ Live Birth 2 ☐ Fetal (4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3	Ectopic pregnanc Other (specify)	у		23d. Date Monti	
as, r.o.	quires that the signed by ald be detact	by	Part II. Other significant conditions contributing to death but not resul End Stage Renal Disease	ting in the ur	nderlying cause giv	ven in Part I.			ute to the cause of death?
Records,	: The law rec cate has bee page 2 sho	Completed	CVA Sepsis				24a. Was an autops perforn 1 Yes 2	y prid ned? dea	ere autopsy findings available or to completion of cause of ath? Yes 2 □ No
	hysician his certifi I director	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	R/Outpatient	Othe	ace of Death <i>(Check</i> er: 4 Nursing Hor		nce 6 X Other	Hospice (Specify)
Division of	Attending P death. ctor: After t y the funera	Certificate:	1 A Natural 5 Pending (Month, Day, Year) 2 Accident Investigation 3 Suicide 6 Could not be	28b. Time of injury		? Yes 2 🗆 No		v injury occurred	or Rural Route Number,
2	pital or / ours after eral Dire filled in b		building, etc. (Specify)			-1	City or Town,	State)	
;	thin 24 h	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowled (Check only one) 3 Certifying Nurse Practioner: To the best of my knowled only one) 4 Certifying Nurse Practioner: To the best of my knowled to the best of my kn	and/or investi	gation, in my opinio eath occurred at the	n, death occurred at the time, date and place	the time, date and e, and due to the o	l place, and due to cause(s) and mann	o the cause(s) and manner stated. ner as stated.
	2		Dobrah Mila	CRNI	P R L	4320		Od. Date signed (N	Month, Day, Year)
12	7	_	30. Name and address of person who completed cause of death (Item 2 Deborah Miller, CRNP 6001 Mu		er Mill R	Rd. Rockv	ille, M	D 20855	
	Stat Registra	_	31. Date filed (Month, Day, Year) JUL 1 9 2011 Lever A. Registra's Signature	ales					

			For State	State of Mary			nt of Health and	Me	-		
			Registrar 1. Decedent's Name (First, Midd	fle, Last)				2.	Reg.	201	3. Time of Death
	Physic		Dana	5/2 10					JU14	Pay 1 2 C	
acqu	/Medi Examir		4a. Facility Name (If not institution	on, give street and number)		4b. Cit	y, Town, or Location of Dea	ath		4c. County of D	
3	- Lxaiiiii	iei	Mallard Ba		nter	0				Doro	4 3
	Funeral		5. Social Security Number	6. Sex 7. Age (I	n yrs. last birthday)		er 1 Year If Under 24 H		Date of Birth	9.	Birthplace (State or Foreign
	Director		231-75-3329	1 1 1 1 1 1 1 1 1 1 1	8 5 Yrs.	Month	s Days Hours Mi	n.	Date of Birth (Month, Day, Ye.	925	Country) Korea
	pu ,		Usual Residence of Decedent						/		
	72 hours after death with the Maryland natural", or items 23a or 28a-f show filest Exercities must be inclifted at	_	10a. State 10b. County		Oc. City, Town or Lo						10d. Inside City Limits 1 ☑ Yes 2 ☐ No
Ç	8a-f	ectc		chester	East 1	Vew	Market Pip Code				
3	vith th	Funeral Director	10e. Street and Number			10f. Z			10g.	Citizen of What	Country?
3	s 23g	sral		ateau Driv	e		21631			451	4
,	item item	Ľ,	11. Marital Status	12. Was Decedent Eve Armed Forces?	r in U.S. 13.	Was Dec	edent of Hispanic Origin? ecify Cuban, Mexican, Pue	(Specifi erto Ric	y Yes or No- an, etc.)		American Indian, /hite, etc.
36	rs aft	by	1 ☐ Never Married 2 ☐ Mai 3 ☑ Widowed 4 ☐ Divorce	If Ves Give		1 ☐ Yes	2 No Specify:			Specify:	100000
ş	tural"			nt's Education	16a. Dece	dent's Us	sual Occupation		16b	Kind of Busine	orean
215-0036		Completed	(Specify only highe	est grade completed)	(Give	kind of v	vork done during most of w use retired)	orking			,
77.	d within giene. r than "	E	Elementary/Secondary (0-12)	College (1-4or 5+)	F	-	Mer		S	elc-c	employed
	be filed value Hygis dother event, II	BeC	17. Father's Name (First, Middle	, Last)		<u> </u>		ame (F	irst, Middle, Maid	len Surname)	1095
<u>a</u>	e d the	To B	Unknou	(N			11nh	(n	DWN		
Maryland	d 2 should th and Mer 7 is marke traumatic		19a. Informant's Name/Relations		19b. Maili	ng Addre	ss (Street and Number or			y or Town, Sta	te, Zip Code)
	alth a		Rebecca	Kim	1381	71	Aura Ratel	CF	· Court /	Pentrev	: 11e VA. 20121
ē,	s 1 and of Healt item 2 other		20a. Method of Disposition		20b. Place of Dispo	osition (N	ame of	Date	20c	Location - City	or Town, State
Baltimore,	Page ent o nt: If ry or		1 M Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (\$	3 Removal from State	Dorchester	,		1131	2011 Cc	ا مدامدا ا	ing MD
	permit. Pag Departmen Important: any Injury once.		21. Signature of Funeral Service		2 2	2. Name	and Address of Facility		20	(MDI'd	ge moi
m	Depa Impo any I		Janolla.	C. Fleure	1. 5	lenr	and Address of Facility 4 Funeral Washingtons	HON	(e) rimi	1	D. 2/613
	-		23a. Fall 1. Enter the disease, o	r complications that caused the						90, 11	Approximate
	Physician		Immediate Cause (Final	t only one cause on each line.	1.4:	10	as a mira la s				Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a co		icier	no carcinor	no			LWEEKS
	Examiner			Duc 10 (01 us u 00	onsequence or,.						
	1000	je.	Sequentially list conditions, if any, reasons to immediate cause. Enter Underlying Cause (Disease or injury that in list and the cause)	b. Due to (or as a co	onsequence of).						
	cuted d ansit	Examiner	Cause (Disease or injury that initiated events								
Š	exec an an rial-tr		resulting in death) Last	Due to (or as a co	onsequence of):						
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0	leath certificate I attending physi I for use as the b	edi									
מא	n cer andin use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p		7				23d. Date of	delivery
0	deat e attr d for	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim		⊒ Ectopic ⊒ Other (pregnancy specify)			Month	Day -Year
5	t the by th ache	hys	9 ☐ Unknown	9 ☐ Unknown							
ν, J.	res that the de signed by the be detached t	by P	Part II. Other significant conditi	ons contributing to death but no	ot resulting in the u	nderlying	cause given in Part I.		23e. Did tobacc	o use contribut	e to the cause of death?
Vital Records,	quire an sig uld b	be						-	1 🗆 Yes	2 No 3	Probably 4 Unknown
2	w requir s been si should I	Completed						1	24a. Was an	24b. Were	autopsy findings available
ב ב	he la te ha	E .						-	autopsy performed	prior	to completion of cause of
<u> </u>	sician: The law certificate has t irector, page 2 sl		25. Was case referred to medica	1					1 □ Yes 2 2	No 1 □'	Yes 2□No
>	ding Physician: The n. n. After this certificate hi funeral director, page	o Be	examiner?	Hospital:	2 ER/Outpatier		0.11		check only one)		<u>-</u>
ō	ding Phys n. After this funeral di	7:1	27. Manner of Death	28a. Date of Injury	28b. Time o				5 Residence		Specify)
<u>.</u>	th.	ig	1 Natural 5 ☐ Pendir 2 ☐ Accident investi		ear) Injury	M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	"""		,,,	
Division	Atter dea ctor	Certification:	3 ☐ Suicide 6 ☐ Could	not be	At home, farm, str	eet, facto		28f.	Location (Street	and Number o	r Rural Route Number,
á.	after Dire	erti	4 ☐ Homicide determ	building, etc. (5	Specify)		,,	1	City or Town, Si	ate)	
	Io the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Within 24 hours after death. The Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier 1 Certifyii	ng Physician: To the best of m	ny knowledge, deat	h occurre	ed at the time, date and pla	ice, and	due to the caus	e(s) and manne	er as stated.
:	e Ho 1 24 h e Fui letely	Medical	(Check only 2 Medical one)	Examiner: On the basis of examiner stated	amination and/or in	vestigation	on, in my opinion, death oc	curred	at the time, date	and place, and	due to the cause(s)
	vithin To th	Me	29b. Signature and title of certifie			2	9c. License number		29d.	Date signed (M	lonth, Day, Year)
	,,,,		· Ra a	e an mai			Ihn saar	72		1/12,1	1/
	U	-	30. Name and address of person	who completed cause of death	(Item 23a) (Tuna	Print)	9c. License number H005997	12	/	110/	//
	~		Patricia - la	100 in 100	Branh	10	St Cambo	1	100 M	0	
-	Sta	e_	31. Date filed (Month, Day, Year)	22. Registrar's	Signature	~	1) 000.101	, 0	2		
	Registra		BH 1A T	MI A.A.	h has	del					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 24341 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 2011 Sylvia R. Seid 4:10 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Timonium Lorien Mays Chapel Social Security Number If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Ye, Dec 28 **Funeral** Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) PA Months 1 M 2 X F **Director** 077-22-2972 101 1909 Dec. Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he position and once. ms 23a or 28a-f show must be notified at 10a, State 10c. City, Town or Location Director 10d. Inside City Limits Baltimore Timonium 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21093 U.S.A. 12230 Round Wood Road 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 9 Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Electronics Manufacturing Elementary/Seconday (0-12) College (1-4 or 5+) 12 Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bessie Golden William Sigal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2901 Anderson Road, White Hall, MD 21161 Barbara R. Rasch/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State July 23, 1 🗆 Burial 2 💢 Cremation 3 💢 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) Cremation Direct Service 2σ11 York, PA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility J. J. Hartenstein Mortuary, kerk Second St., New Freedom, PA 17349 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one of nset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine signed by the attending physician and deetached for use as the burial-tranthat initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Day Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed Was an . Were autopsy findings available prior to completion of cause of To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has k autopsy 1 ☐ Yes 2 ☐ No 2 🗍 No 25. Was case rest examiner 1 \(\sum \) Yes funeral director, Be 26. Place of Death (Check only one) 2 D Other: ဂ Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) pleted filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 68m Name and address of person who completed caus of death (Item 23a) (Type, Print) N Charles Street 6701 Commic 31. Date filed (Month, Day, Year) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Wilma Frances Taylor () 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. Cjty, Town, or Location of Death 4c. County of Death **Examiner** b 0 Age (In yrs. last birthday)
75 yrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Maryland 1 🗆 M 2 😾 F Months Month, Day, Year) 1-09-1935 215-36-1241 Director Usual Residence of Decedent show 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location notified at Director Somerset Md. 28a-f Chance 1 ☐ Yes 2 K No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? must be Funeral United States 21821 23a 23664 Deal Island Road items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, injury or other traumatic event, the Medical Examiner Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc ō ģ 1 Never Married 2 Married If Yes, Give Year or Dates 1 Yes 2 No Specify: White "natural", Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Domestic Engineer Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Margaret Belt 2 George Dryer 19a. Informant's Name/Relationship (Type, Print)
Skip Taylor—Son 19b. Mailing Address (Street and Number of Rural Route Number City of Town, State Zio Code) 33042 Department of Health a Important: If item 27 is any injury or other trat 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Salisbury Crematory Salisbury, Md. 7-14-2011 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hinman Funeral Home M00295 21853 11673 Somerset Ave., Princess Anne, Md. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. Approximate Interval Between Implediate Cause (Final Onset and Death Ph_sician/ D10my disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Directors Affair this manner. Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery signed by the atte in the past 12 months? Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? g 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 s autopsy performed death? ☐ Yes completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Tyes ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending 1 Tes Investigation 6 Could not be Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Sulcide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. and title of certifie 29b. Signatur

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

(AU

address of person who completed cause of death (Item 23a) (Type, Print)

130

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Physician/ 0048 11 Lois G. Webb Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Easton Talbot Memorial Hospital at Easton If Under 1 Year If Under 24 Hrs.

Manths Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months 05 (Manth, Day) Year Country) 79 MD Director 217-30-6737 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 🔀 Yes 2 □ No MD Talbot Easton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 205 Prospect Ave 21601 IISA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates. Specify: White Completed 3 Widowed 4 Divorced Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ permit, Page 1 and 2 should be i Department of Health and Menta Leonard Fox Dorothy Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gerald Webb (Husband) Easton MD 21601 205 Prospect Ave Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State Chesapeake Cremation 07-11-2011 4 ☐ Donation 5 ☐ Other (Specify) Stevensville, MD Center 22. Name and Address of Facility
Fellows, Helienbein & Newnam Funeral Home, P.A.
200 S. Harrison St Easton MD 21601 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death, Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Inset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Pnysician/ Due to (or as a consequenc Of) disease or condition resulting in death) hours Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Other (specify) Pregnant at time of death sate has been signed by the page 2 should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? r this certificate had director, page 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred After Natural iniury 5 Pending Accident Investigation 24 hours after death Funeral Director: 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F 3 🗆 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 64043 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) South Washington State Registrar

Webb

Phys /Me Exan

Funer Direct

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

	1	For State Registrar			irtment of H <i>rtificate of L</i>				201	1	24344		
		1. Decedent's Name (First, Middle, Last)					2. Date of De		ay and	ear/	3. Time of Death		
cian dical	-	Elzey Calvin Willey					July	14	201		07:10 A M		
niner		4a. Facility Name (If not institution, give street and number)				Location of Death			c. County of		2.76		
		3860 Vincent Road	a da um lantid	Maradan v s V	Linkwoo	od If Under 24 Hrs.	R Data of Bir	1	Dorch				
al or		214-07-8108 1™ 2□F	e (In yrs. last birt	Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Di Feb • 2	iy, Year	916 M	lary	place (State or Foreign htry) Land		
	- 1	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Lo	cation					1	10d. Inside City Limits		
è		Maryland Dorchester	Link								1 ☐ Yes 2 🛣 No		
100	3	10e. Street and Number			10f. Zip Code			10g. C	Citizen of Wh	at Cour	ntry?		
Funeral Director	5	3860 Vincent Road			21	835			USA				
ler.	5	11. Marital Status 12. Was Decedent Armed Forces?		13.	Was Decedent of Hi	ispanic Origin? (Sp	ecify Yes or No)-			can Indian,		
11. Marital Status 1 Never Married 2 Married 5 Never Married 2 Married 5 Never Divorced 1 Never Married 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1945 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American In Black, White, etc. 15 Yes, Give Year or Dates: 1945													
Pet	15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry										-		
1		Elementary/Secondary (0-12) College (1-4or 5	5+) T7- 7	life. I	DO NOT use retired))	9		ımber				
		/	wel	Lde	<u> </u>	18. Mother's Name	- (Cimt Middle				s Union		
å	מ	17. Father's Name (First, Middle, Last)					Bessie			/			
ß	2	John Willey 19a. Informant's Name/Relationship (Type. Print)	19h	Mailir	ng Address (Street					tate. Zii	p Code)		
		Rita V. Willey-Crockett/Daus			Crockett						, ,		
		20a. Method of Disposition	20b. Place of		sition (Name of natory or other plac		Date		Location - C		own, State		
	-	1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation ☐ Other (Specify) 21. Signature of Funeral Service Licensee	1	Wasl	hington Cen	n. 7/18	/2011		-		yland		
once		21. Signature of Funeral Service Licensee	Eller		Name and Address eller Fun 06 Main S	eral Home treet, Ea	e, P. O ast New	· Bo	ox 207 rket,	MD			
6		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immudiate Cause (Final disease or condition resulting in death) Due to (or as is consequence of): Due to (or as is consequence of): Due to (or as is consequence of):											
n `		disease or condition a.	gest	ي د	Hear	+ tail	we			_	112		
al er		Due to (or as	consequence	of):	· die	0000					1015		
Į į	<u>.</u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as	a consequence		E Ous	21/8				_	10/1		
Fyaminer		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.											
	ן נֿ	resulting in death) Last Due to (or as	a consequence	of):									
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		IF FEMALE:											
in in	<u>a</u>		2 Fetal death		Ectopic pregnanc	у			23d. Date Mon		very Day Year		
Physician/M	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	at time or death	5 L	Other (specify) _								
		Part II. Other significant conditions contributing to death b	out not resulting in	n the u	nderlying cause give	en in Part I.	23e. Did	tobacc	o use contri	bute to	the cause of death?		
Completed by	ב ב	Type 2 DiAbetes	Pro				1 🗆	Yes	No :	3□ Pro	bably 4 🗌 Unknown		
4	ובונ	7.7 \$					24a. Wa		24b. W	ere aut	opsy findings available ompletion of cause of		
<u> </u>	5						per 1 🗆 Yes	opsy ormed? 2 X	₹ de	eath?	2 No		
Re		25. Was case referred to medical examiner?				26. Place of Deal							
			ent 2 ☐ ER/Ou	ıtpatie	nt 3 DOA Oth	er: 4 Nursing He	ome 5 Res	idence	6 □Othe	r (Spec	ify)		
	<u>:</u>	27. Manner of Death Satural 28a. Date of Injuty (Month, Death) (Month, Death)		Time o njury	Worl	k?	28d. Describe	how in	jury occurre	d			
tea	2	2 Accident investigation 3 Suicide 6 Could not be	A4 h 6-			Yes 2 □No	201	(011			Doute Number		
Prtif		data umin ad 200, Place of III	tc. (Specify)	irm, su	eet, factory, office		City or To	own, St	and Ivumbe ate)	rornu	ral Route Number,		
S Ist	5	29a. Certifier (Check only (Ch											
Medical Certification: To	אובחור	one) and manner st		10/01 11	29c. Licens		ned at the time				n, Day, Year)		
		> mftalden	The second of the second of				8						
		30. Name and address of person who completed cause of a Michael Frielder Mi	death (Item 23a)	(Type,	Print)	ferlow	le ma	1	216	4	3		
State	•	****	rar's Signature	1	ad								
strar		JUL 15 2011 \ 2000	m p.	10									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 20°11 3:59 A Phyllis E. Younker June Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Clear Spring 232 Cumberland Street 9. Birthplace (State or Foreign Country) MD If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Social Security Number 7. Age (In vrs. last birthday) 1 □ M 2 🛛 F Months Days Hours 12/23/1932 78 Yrs. **Director** 214-28-0170 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1X Yes 2 ☐ No MD Washington Clear Spring 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21722 232 Cumberland Street USA hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married δ Yes 2 X No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Il Hygiene. other than "natural", If Yes, Give Specify: 3 X Widowed 4 ☐ Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 10 Homemaker Be other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be file h and Mental H 7 is marked of Elizabeth Gertrude Householder Luther C. Kesecker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is 1025 Mace Avenue Baltimore, MD 21221 Deborah J.Filling/Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 and Department of H 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) injury or Parkhead Cemetery 06/24/2011 | Big Pool, MD 21. Sanatur of Funeral Service Licens 22. Name and Address of Facility 141 West Main Street Grove Funeral Home, P.A. Hancock, MD 21750-0368 M00260 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician disease or condition resulting in death) Medical **Examiner** Sequentially list conditions. Examine il any leading to in medicause. Enter Underlying Infection **Hospital or Attending Physician:** The law requires that the death certificate be executed 24 hours after death. nding physician and use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed certificate 1 Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 - Pending safter death.

Director: Aff
d in by the fur 1 🗌 Yes 2 🗌 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical

within 24 hours aft

To the Funeral Di

completed filled in

DHMH 17 Rev 7/2009

State

Registrar

29a. Certifier

(Check

only one) 29b. Signature

31. Date filed (Month, Day,

2011

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Description of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

MDOO

29d. Date signed (Month, Day, Year)

2011

Certifying Nurse Practionen To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State of Maryland / Department of Health and Mental Hygiene 24346 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month July Physician $20^{\circ}1^{\circ}1$ 6:50 A M Herbert Edward Albert /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 34 Peartree Lane Colora Cecil 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan 17, 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Maryland 1 X M 2 □ F Months Days Hours Min. 1944 177-34-1517 67 **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Event in a must be notified at 10d. Inside City Limits Funeral Director Cecil Colora 1 ☐ Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code USA 21917 34 Peartree Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No 1965 If Yes, Give Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 white 1 □Yes 2 No Completed by Specify: 3 Widowed 4 Divorced Year or Dates 1967 16b. Kind of Business/Industry unit 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Morris Albert Ann Albert McFadden ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 34 Peartree Lane; Colora, Maryland 21917 Rosemary Albert - wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Signature of Funeral Service RODA I d 22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore St; Baltimore, MD 21201 23a. Lirt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, suck or heart failure. List only one cause on each line.

Immediate ause (Final disease or condition) Approximate Interval Between Onset and Death Stag **Physician** disease or condition resulting in death) years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran the attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Month Year Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown n signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 No 2 No 1 ☐ Yes 1 🗌 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 | Inpatient After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal 29a. Certifier (Check only one) within 2 To the 29b. Signature and title of certifier. 29d. Date signed (Month, Day, Year) A. BAHLRAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ASHKAN 32. Registrar's Signature State Registrar

า-บองาษ Rasheed Abdull	ah	State of Maryland / Departme				
tugiloou / toudil		1- For State Certifica	te of Death	Reg.	2011	24347
Physici		Registrar 1. Decedent's Name (First, Middle,Last)		2. Date of Death		3. Time of Death
Medical Exami	ner	Total District		July 17, 201	1	0555 hrs
		Facility Name (if not institution, give street and number) 1203 Ward Street	4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
		5. Social Security Number 6. Sex 7. Age (In yrs. last birth		R Date of Right	MM/DD/YYYY) 9. Birth	anlace (State or
Funeral Director			Months Days Hours Min.	Dec. 12,	Foreign	1
		217-29-4300 1 M 2 F 21	Yrs.	14. 12,	, 1505 600	ntry) Maryland
ĥ.		10a. State 10b. County 10c. City, Town of	r Location			10d. Inside City Limits
nd show	-	MD N/A Baltimo	re			1 Yes 2 No
Maryland 28a-f sho	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Count	ry?
21215-0036 uld be filed within 72 hours after death with the Maryland Mental Hyggene. marked other than "natural", or items 23a or 28a-f sho e event, the Medical Examiner must be notified at once.		1121 S. Carey Street	21223		USA	
h with	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces?	 Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 	ecify Yes or No- Rican. etc.)	14. Race - Americ White, etc.	an Indian, Black,
or deal	쿄	3 Widowed 4 Divorced If Yes, Give Year			specify: Blac	sile
rs afte ural"	ā	or Dates:	1 Yes 2 No specify: ecedent's Usual Occupation (Give kind of v	ork done	Speary: D.Lac	
5-0036 led within 72 hours Hygiene. other than "natur. the Medical Exami	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	uring most of working life. DO NOT use reti			,
036 ithin and reference	Ē	10th Grade	Distributor		F.P. Winne	er
5-0 led w Hygie othe		17. Father's Name (First, Middle, Last)		(First, Middle, Mai	den Surname)	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	Bilal Yusef M. Abdullah	Arey Lee			
이 용 문 교 별	잍		Mailing Address (Street and Number or F 21 S. Carey Street			
Baltimore, MC permit. Pages I and 2 st Department of Heath an Important: If item 27 injury or other trauma		20a. Method of Disposition 20b. Place of	Disposition (Name of cemetery,		Oc. Location - City or T	
Baltimore, permit. Pages I an Department of He important: If ite injury or other tr		Telloval for otals	y or other place) Mount Cemetery 8/	1/2011	Baltimore,	Marvland
it. Partment ortan	-	4 Donation 5 Other Specify: Green 21. Signature of Funeral Service Licensee	1			
De De di i		Culler Harris	5240 Reisterstown	auman-nai Road Balt	rris Funera timore, MD.	21215
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not failure. List only one cause on each line.				Approximate Interval Between Onset and
/Medical £xaminer		Immediate Cause (Final disease a. Multiple Gunshot Wounds				Death
67		or condition resulting in death) Due to (or as a consequence of):				
	9	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
	Examiner	cause. Enter Underlying Cause (Disease or Injury that Initiated Levents resulting in (earth) Last Due to (or as a consequence of):				
ansit	МÄ	events resulting in death) Last Due to (or as a consequence of): d.				
executed ian and ial - transit	ical	UNPENDED AMENDED				
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68760, certificate buding physicses as the bur	Ē	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 4 Pregnant at time of death 5	Fetal death 3 Ectopic pregna	ncy	Month Da	ay Year
Box c death c the attent of for us	Physician/Med	1 Yes 2 No 9 Unknown g Unknown	Other (Specify)			
. 2 7 2 1		Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.	23e. Did toba	cco use contribute to th	ne cause of death?
i, P.O. ires that the signed by the detac	Completed by			1 Yes	2 No 3 Proba	bly 4 Unknown
ords, w requir	<u>ş</u>			24a. Was an autopsy		ppsy findings available mpletion of cause of
Cecc	E			performe 1 ✓ Yes 2	d? death? No 1 ✓ Yes	2 No
	Bec	25. Was case referred to medical examiner?	26.Place of Death (Check of	only one)		
of Vital Records, of Physician: The law require ufter this certificate has been si meral director, page 2 should t	P	1 ✓ Yes 2 No Inpatient 2 ER/Out			sidence 6 🗸 Other:	Scene
- 4 . 4 2 1		27. Manner of Death 28a. Date of Injury 28b. T 1 Natural 5 Pending Jul (Manth, Day, Year) 0551	me of Injury 28c. Injury at Work? hrs 1 Yes 2 ✓ No	28d. Describe how Subject shot	/ injury occurred	
SiO Atten r death ector: by the	g	2 Accident Investigation 28e Place of Injury - At home for	m, street, factory, office building, etc.	28f Location (Stre	et and Number or Rura	al Route Number City
Division ral or Attendii rs after death.	Certification:	3 Suicide 6 Could not be determined (Specify) Local Street		or Town, State 1203 Ward Stree	et, Baltimore, MD	arriodic Humbor, Ony
Divis the Hospital or A hin 24 hours after the Funeral Dire		29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, deat				<u> </u>
Division To the Hospital or Attency within 24 hours after death To the Funeral Director: completely filled in by the	Medical	one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.				
FSFS	ğ	29b. Signature and title of certifier	29c. License number		9d. Date signed (Mont	h, Day, Year)
		Clueb	O.C.M.E.	J	luly 17, 2011	
,		30. Name and address of person who completed cause of death (Item 23a)	Rollimoro Stroot Baltimore ME	1 21222		
	ata	Ana Rubio MD. Assistant Medical Examiner 900 W 31. Page filed (Month, Day, Year) 32. Registrar's Signature	. Dailimore Street, Dailimore, ML	, 2 1223		
Regis		ALTERNATION TO ANALY				

ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 24348 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ $J_{\mathbf{u}}^{Month}$ 2ÕT1 Clyde E. Brown Jr. 2:20 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Casey House Rockville Montgomery 5. Social Security Number Birthplace (State or Foreign Country)

 Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** May 29, 1953 1 X M 2 □ F Months Days Hours Min. 58 **Director** 216-60-2467 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director MD Montgomery Silver Spring 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? must be Funeral 2601 Bel Pre Rd. 20906 23a USA items within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, er than "natural", or ite the Medical Examiner Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black. White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation unk
(Give kind of work done during most of working 16a. Decedent's Usual Occupation 16b. Kind of Business Industry unk I Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) unk unk it. Page 1 and 2 should be filed wirthent of Health and Mental Hygie rtant: If item 27 is marked other njury or other traumatic event, ti Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Casey House 6001 Muncaster Mill Rd; Rockville, MD 20855 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or or ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 🕅 Other (Specify)in state 22. Name and Address of Facility State Anatomy Board Signature of Funeral Service Licensee Nirector 655 W. Baltimore St; Baltimore, MD 21201 23a. Palt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest show, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final Onset and Death Physician/ metastatic colon cancer disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or iinjury use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 led by the attending p detached for use as IF FEMALE: outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. vate nas been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4 ♣ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an autopsy performed? certificate Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 X No Other: hospice မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred X Natural injury 5 Pending work? 2 No Accident Investigation within 24 hours after death

To the Funeral Director;
completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License numbe 7/1/2011 D37142 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Coleman 6001 Muncaster Mill Road; Rockville, Maryland 20855 31. Date file AUG 0 32. Registrar's S State

DHMH 17 Rev 7/2009

Registrar

11-05621	
Cathy Bridges	

Cathy Bridges		S 1- For State Registrar	tate of Maryla		artment of <i>rtificate of</i>		nd Menta	al Hy		g. No.		2431	19
Physicia	an/	Decedent's Name (First, Midd	lle,Last)					2	2. Date of Deat Month	Day Yea		3. Time of Death 2055 hrs	
Medical Exami	ner	Ca 4a. Facility Name (if not institution		dges		b. City, Town, o	r Longtion of	Dooth	July 27, 20	11 4c. County	of Death	2000 1118	
		Harbor Hospital	on, give street and ni	imber)	,	Baltimore	Location of	Death		40. Godiny	o, Doda,		
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Yes	ar If Under	24Hrs.	8. Date of Birt	h(MM/DD/YYY)			
Director		040-58-5318	1 M 2 XF	54	Yrs.	Months Day	ys Hours	Min.	03/3	1/1957	Foreigr Cou	intry) MD.	
	İ	Usual Residence of Decedent									т	40d Incide City Line	ita
w any		10a. State 10b. County	arles	10c. City	, Town or Locati	on dorf						10d. Inside City Lim 1 X Yes 2	
Aaryland 28a-f show	ġ	MD. Cho	arres		wai	10f. Zip Code			110	Og. Citizen of W	hat Coun		_
ith the Maryland 23a or 28a-f sho notified at once.	Director	2320- Нор	o Ciralo			206	01			U.S		•	
with the s 23a e noti		11. Marital Status		cedent Ever in U	J.S. 13. Wa	s Decedent of H	ispanic Origir	n? (Spe	cify Yes or No-	14. Race	- Americ	can Indian, Black,	_
death r	Funeral	1 Never Married 2 N	farried Armed F	orces?	If Ye	es, specify Cuba	ın, Mexican, I	Puerto F	tican, etc.)		e, etc.	-	
after all", o	δy		vorced If Yes, Give Yes or Dates:	ar		Yes 2 X N					Bla		_
hours fram		15. Decedent's Education (Specific Elementary/Secondary (0-12)				t's Usual Occupa ost of working life				16b. Kind of Bu	usiness/ir	ndustry	
36 hin 72 than than dical	를	Elementary/Secondary (0-12)	2	1-4 0(5+)	Sec	retary				Priv	ate		
21215-0036 Juld be filed within 72 hours after death with the Maryland Mental Hygiene. marked other than "natural", or items 23a or 28a-f she e event, the Medical Examiner must be notified at once	Completed	17. Father's Name (First, Middle	e, Last)		<u> </u>		18.Mother's	Name (First, Middle, N	laiden Surname	9)	-	_
2121. 2121. Mental Fill marked	Be	Donald L	. Studev	ent					Hill			<u></u>	_
Should and Mand Mand the control of the matter of the matter of the mand the control of the cont	٩	19a, Informant's Name/Relation		10		Address (Stre							
nd 2	-	DeCarlo T. 20a. Method of Disposition	Bridges	/ Son 20b.	Place of Dispos	4th S ition (Name of co		- , <u>1</u>	Date Date	20c. Location	- City or	Town, State	_
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Baltimo permit. Page Department of Important: injury or oth		4 Donation 5 Other 5 21. So ature of Funeral Service	Specify:		verdal	lame and Address [ackett							
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Physician		23a. Part I. Enter the disease, of failure. List only one cause	r complications that one on each line.	pertens	n. Do not enter the ive Ath e	ne mode of dyng eroscle:	such as car	rdiac or Card	respiratory arre	est, shock, or he ular Dis	ease	Approximate Inter Between Onset a	
/Medical Examiner		Immediate Cause (Final diseas	e a compli	cated b	y cocai							Death	- 1
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auted nd ransit	ŭ	events resulting in death) Last	d	•									
60, e be executed ysician and burial - transit	edical	x UNPENDED	AMENDED	23a,27,	28a-f,p	er me,g9	18 8-3	3–11	sm				
760, icate be physici	/Me	IF FEMALE: 23b. Was decedent pregnant in		outcome of pre		tal death 3	Ectopic	prognan	.0.4	23d. Date o Month		ay Year	
Box 6876 e death certificate the attending phy ed for use as the l	cian	past 12 months?	4 Preg	nant at time of d		tal death 3 her (Specify)	Ectobic	pregnan	Cy	Month		idy Tour	
BO) e death the att	Physician/M	1 Yes 2 No 9 🗸 Ui	3 Onia						_				
that the detach	by P	Part II. Other significant cond	itions contributing t	to death but not	resulting in the u	inderlying cause	given in Par	t I.		_	_	the cause of death?	'n
Division of Vital Records, P.O. raterating Physician: The law requires that the safe death. In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	P P	W							24a. Was			topsy findings availa	_
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tal Rec	ပ္ပြ					00 Black	ce of Death (Charles	1 Yes	2No	Ye	s 2 No	
ician:	æ	25. Was case referred to medic examiner?	Hospital:	Inpatient 2	ER/Outpatient		104			Residence 6	Other		_
of V ing Phy After thi uneral d	7.	1 Yes 2 No 27. Manner of Death		e of Injury	28b. Time of I		jury at Work?	7 7	28d. Describe I	how injury occur	тed		
lon leadin eath.	턇			7-27-11	unk	1	Yes 2 K	No g	subject	took d	rug		
or At or At offer d Direct in by	Certification	3 Suicide 6 Co	uld not be 28e. Pla		home, farm, stree	et, factory, office	building, etc	. [28f. Location (\$ or Town, \$	Street and Number (1906)	ber or Ru Cheri	ral Route Number, C ryland Ave	ity
Spital spital hours a	Cer	4 Homicide		A Resi	-			l)	<u>laltimo</u>	re,Md.			
Division of Vital Records, P.O. Box 6876 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the l	Medical	(Check only	Physician: To the be aminer:On the basis	est of my knowle of examination	dge, death occur and/or investigat	rred at the time, tion, in my opinio	date and plac on, death occ	ce, and o curred at	the time, date	se(s) and manne and place, and	due to the	e cause(s)	
To t With To t	Med	29b. Signature and title of certif	and manner				nse number					nth, Day, Year)	_
	1000	(as se	Hele	lan	_	0.0	M.E.			July 28, 2	011		
		30. Name and address of person				<u> </u>							
			ssistant Medica		900 W. Bal	timore Stree	t, Baltimo	re, MC	21223				
S	tate	3/416110 (12011) ear	Jan 32. F	Registrar's Signa	Bille!								

OCME

			For State Registrar	State of Maryl		rtment of Hea tificate of De			2011	24350
	Physici	an	Decedent's Name (First, Middle, Last)		0			ate of Death	Day Year	3. Time of Death
	/Medic		Maxie		Dr	ewer) (414	2.5 20\\ 4c. County of Deat	. 1 . 0
	Examin	er	4a. Facility Name (If not institution, give st	KINS HOSE	otal	4b. City, Town, or Lo	mre C	tu	N/A	
	Funeral		5. Social Security Number 6. Sex	M 0 0 5	yrs. last birthday)		f Under 24 Hrs. 8. D Hours Min.	pate of Birth Month, Day, 24, 1		hplace (State or Foreign untry)
	Director		212-32-5914	WI ZLIF	74 Yrs.		Oct	24, 1	936	Maryland
	aryland show		10a. State 10b. County	100	c. City, Town or Loc	ation				10d. Inside City Limits
	e Mar 8a-f s	Director	MD N/A	. Ba	altimore					1 ☑Yes 2 No
	with the	Dire	10e. Street and Number 1426 N. Gay Street			10f. Zip Code	213	10	g. Citizen of What Co USA	untry?
	death ms 23 must	Funeral		2. Was Decedent Ever	in U.S. 13. V		anic Origin? (Specify Mexican, Puerto Rica	Yes or No-	14. Race - Ame	rican Indian,
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, it a Morton Examiner must be notified at		1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces?/ 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		. /	Mexican, Puerto Rical Specify:	n, etc.)	Black, White Specify: B.	lack
5-0	72 hc "natui	Completed by	15. Decedent's Educa (Specify only highest grade	ation completed)	I (Give I	ent's Usual Occupation	on ing most of working	1	6b. Kind of Business/	Industry
121	within iene. than	dwo	Elementary/Secondary (0-12) 12th Grade	College (1-4or 5+)	l l	no NOT use retired) Maintenance	е	E	Baltimore (City
	al Hygi other vent, I	BeC	17. Father's Name (First, Middle, Last)				3. Mother's Name (Fir		laiden Surname)	
ylar	Mental Mental arked or	10 E	Maxie Lee Brewer,	Sr.]	Lottie Dou	glas		
Maryland	12 should th and Mer 7 is marke traumatic		19a. Informant's Name/Relationship (Typ Delphine Griffin -	,		•			City or Town, State, 2	
	f Health tem 27 other tra		20a. Method of Disposition			sition (Name of natory or other place)	Date		Oc. Location - City or	
mo	Pages nent of l tnt: If ite		1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	moval from State		at'l Mem. Par	k 7/29/20	011	Laurel, Ma	ry.land
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tt		21. Signature of Funeral Service Licensee	emo		Name and Address	Chatr	man-Ha d Balt	rris Funer imore, MD.	ral Home 21215
			23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the cause on each line.						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	Pumor	Ary	Empousi	м.			Onset and Death
4	/Medical Examiner		resulting in dodary	Due to (or as a cor	nsequence of):					
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O. Box	Physician: The law requires that the death certi this certificate has been signed by the attending rai director, page 2 should be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □No 9 □Unknown	c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)		_	23d. Date of de Month	livery Day Year
ds, P.	uires that signed by d be deta	þ	Part II. Other significant conditions cont	ributing to death but no	t resulting in the ur	derlying cause given	in Part I.		acco use contribute to	
of Vital Records,	he law require e has been si age 2 should b	Completed						24a. Was ar autops perform	y prior to death?	utopsy findings available completion of cause of
ital	siclan; The l certificate harector, page	BeC	25. Was case referred to medical examiner?			2	6. Place of Death (Cl	1 □ Yes 2 neck only one		S 2 🗆 NO
of V	Physic this ce al dire	၉	1 Yes 2 No		2 ER/Outpatien		<u>~</u>		nce 6 Other (Spe	ecify)
on (ffe	tion	27. Man er of Death 1 ✓ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Yea	ar) 28b. Time of Injury	Work?	at 28d. s 2 □ No	Describe ho	w injury occurred	
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, streepecify)		28f.	Location (Sti City or Town	reet and Number or R ı, State)	ural Route Number,
	e Hospita 124 hours e Funeral letely fille	Medical C	29a. Certifier (Check only one)	ician: To the best of my er: On the basis of exa and manner stated.	y knowledge, death amination and/or in	n occurred at the time vestigation, in my opir	, date and place, and nion, death occurred a	due to the catthe time, da	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)
_	To the vithir comp	Me	29b. Signature and the of certifier			29c. License n	number	25	9d. Date signed (Mon	th, Day, Year)
				/		Res	000	7	uly 2	5 2011
			30. Name and address of person who cor	Thans	(Item 23a) (Type,	Print) 000 N. WO	He Stre	et, B	altimore,	MD 21287
	Sta Registr		AUG (Manth 201 Year)	32. Registrar's S	parket					

DHMH 17 Rev 1/2001

11-05294 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Jerome Jerry Brewer, Jr. 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3 Time of Death Physician/ Month Day July 16, 2011 0540 hrs Medical Examiner Jerome Jerry Brewer, Jr. 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 4713 Roland Ave **Baltimore** N/A If Under 1 Year If Under 24Hrs, 8, Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Foreian Months Days Hours Director Country) Maryland 217-02-5134 1 M 2 F May 28, 1969 42 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1 Yes 2 No MD N/A Baltimore ges 1 and 2 should be filed within 72 hours after death with the Maryland at of Health and Mental Hygiene.

1: If item 27 is marked other than "natural", or items 23a or 28a-f she other traumatte event, the Medical Examiner must be notified at once Director 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? 1361 Winston Avenue USA 21239 11, Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Funera If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 Married Yes specify: Black 1 Yes 2 No specify: 3 Widowed 4 Divorced If Yes, Give Year 3 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Coppin State College Grounds Keeper 12th GRade 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Jerome Jerry Brewer, Sr. Sallie Mae Johns 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sallie M. Mitchell - Mother 1361 Winston Avenue Baltimore, Maryland 21239 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 Burial 2 Cremation 3 Removal from State Pages 1 Maryland Nat'l Mem. Park 7/23/2011 Laurel, Maryland 4 Donation 5 Other Specify: 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Chatman-Harris Funeral Home uller Carres 4210 Belair Road Baltimore, Maryland 21206 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death a Heroin Intoxication and cocaine use Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and Physician/Medical AMENDED 23a, 27, 28a-f, per me, g918 8-3-11 sm attending physician or use as the burial -✓ UNPENDED The law requires that the death certificate be Box 68760. 23d Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Year Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown n signed by the a d be detached fo Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 夏 1 Yes 2 ✔ No 3 Probably 4 Unknown Completed has been si 24a. Was an 24b. Were autopsy findings available prior to completion of cause of performed' death? Yes 2 No this certificate 1 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) 8 Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗸 Other: Scene 1 🗸 Yes ၉ After 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 1 Yes 2 X No Unknown 5 Pending Director: fd 7-16-11 ffd 5:27 am 2 ___ Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 6 X Could not be 3 Suicide or Town, State) 4700 Blk. Roland Ave. altimore, Md. found in auto determined (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: 1 the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of 29c. License number O.C.M.E. July 16, 2011

State Registrar

OCME 2006

DHMH 17 Rev 1/2001

OCME

Mary G. Ripple MD.

900 W. Baltimore Street, Baltimore, MD 21223

person who completed cause of death (Item 23a)

Deputy Chief Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 22 Pay 2011 Year **Physician** Lois Barnhart 0820 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Arnold Future Care Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Days Min Hours 1 □ M 2 🔽 F 89 217-18-6677 Maryland 01/11/1922 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evaninar must be notified at 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2 ☑ No **Funeral Director** Maryland Anne Arundel Arnold 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States of America 21012 268 Foxfire Court 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 □ Yes 2 No Specify: White Completed by 3 X Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clerical Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Catherine Bayless Herbert Burns မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 268 Foxfire Ct., Arnold, Maryland 21012 Carolyn Choroszei (daughter) Baltimore. 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 07/26/2011 Havre de Grace, Maryland Angel Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Zellman Funeral Home, P.A. 21078 21. Signature of Funeral Service bice 123 S. Washington St., Havre de Grace, Maryland 23a. Part 1. Enter the stream, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Years Advanced Alheimer's Dementia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Ye ar in the past 12 months? 1 ☐ Yes 2 ②(No Day 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 □Yes 2 💢 No 1 ☐Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation n 24 hours after death.

In Funeral Director: A pletely filled in by the fu 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

State Registrar

DHMH 17 Rev 1/2001

completely

within 2 To the I

29a. Certifier

29b. Signa

(Check only one)

and title of certifier

Jennißer Riedinger

82. Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

D50725

8601 Veterans Hwy, Millersville, MD 21108

29c. License number

29d. Date signed (Month, Day, Year)

07-22-2011

11-05693	
Tony Bennett	

Tony Bennett	1- For State Registrar	tate of Maryland /	Department of Certificate of		Mental Hy		g. No. 201	1 24353
Physician/ Medical Examiner	1. Decedent's Name (First, Midd		Bennet	+		2. Date of Death Month July 30, 20	Day Year	3. Time of Death 0306 hrs
	4a. Facility Name (if not institution Union Memorial Hosp			4b. City, Town, or Lo Baltimore	ocation of Death		4c. County of De	ath
Funeral Director	5. Social Security Number 216-54-1662	6. Sex 7. Age	(In yrs. last birthday)	If Under 1 Year Months Days s.	If Under 24Hrs. Hours Min.	_	h(MM/DD/YYYY) 9. I - 1949	Birthplace (State or eign Country) MD
and show any nce. Or	Usual Residence of Decedent 10a. State 10b. County MD		10c. City, Town or Loca	ition				10d. Inside City Limits 1 Yes 2 No
n the Maryland 3a or 28a-f show officed at once.		KLAEUN AL	venue	10f. Zip Code 212	.13	10	og. Citizen of What Co U . S	
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 M 3 Widowed 4 Di	12. Was Decedent I Armed Forces? 1 Yes 2 Vorced If Yes, Give Year or Dates:	No If	as Decedent of Hispo Yes, specify Cuban, I	Mexican, Puerto specify:	Rican, etc.)	14. Race - Am White, etc.	WAI+e
5-0036 ed within 72 hours tygiene. other than "nature the Medical Exami	15. Decedent's Education (Spe Elementary/Secondary (0-12)	ecify only highest grade com	+) during n	nt's Usual Occupationost of working life. E	OO NOT use retir	red)	16b. Kind of Busines	1
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and 2 should realth and Meritem 27 is man traumatic cv		HAMILTON-C	20b. Place of Dispo	sition (Name of ceme			BA/bo M 20c. Location - City	
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ted Insit Examiner	Sequentially list conditions,	b. Due to (or as a conse						
10, e be executed ysician and burial - transit		Due to (or as a conse	quence of): ,27,per me,	~010 0 25	11 am			
760, icate be execut physician and the burial - tra	IF FEMALE: 23b. Was decedent pregnant in t	23c. If yes, outcom	e of pregnancy		Ectopic pregna		23d. Date of deliv	
). Box 6876(the death certificate the attending phy- ched for use as the b Physician/Me	past 12 months?	1 Live birth 4 Pregnant at t	ima of doath	etal death 3 ther (Specify)	_Ectopic pregna		Month	Day Year
cords, P.O. B law requires that the d has been signed by the 2 should be detached:		tions contributing to death	but not resulting in the	underlying cause giv	ren in Part I.	1 Yes	2 ✓ No 3 P	to the cause of death?
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Vital hysicians this certification of director of Be	25. Was case referred to medical examiner? 1 Yes 2 No	11. 11.	nt 2 🗸 ER/Outpatien		of Death (Check of other:4 Nursin		Residence 6 Oth	ner:
Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificatel completely filled in by the funeral director, page ledical Certification: To Be Com	27. Manner of Death 1 X Natural 5 Pen	28a. Date of Injur (Month, Day,Ye ding stigation	y 28b. Time of		at Work?	28d. Describe h	ow injury occurred	
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To the Hos within 24 h To the Fun completely	Cornect only	thysiclan: To the best of my						
To Coro	29b. Signature and title of certific	and planner stated.		29c. License O.C.M			29d. Date signed (A. July 31, 2011	Month, Day, Year)
ole do DEME	30. Name and address of person Mary G. Ripple MD.	n who completed cardse of de Deputy Chief Medic) W. Baltimore	Street. Baltin	nore, MD 21:	223	
State Registrar	31. Date filed (Month, Day, Year,		I- 0!	Ke				

24354

3. Time of Death

10d. Inside City Limits

Approximate Interval Between Onset and Death

Year

1 🗆 Yes 2 💢 No

Ам

3:20

Registrar DHMH 17 Rev 7/2009

State

JACKIE JONES,

AUG 0

31. Date filed (Month, Day, Year,

CRNP

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

amend Item 25 per me. g918 8-3-11 sm Amend Item 25 per me. g918 8-3-11 sm Officer Amend Item 23a per dr. g918 08/01/2011dhb 1-state Registrar Amend #27per ME, G918, 08/11 (1987) 20 4 4 4 hb Reg. No. 24355 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2011 **Physician** Cooke 5:16 AM arl /Medical 4a. Facility Name (If not institution give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Good samaritan Hospital N/A Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 ☑ M 2 ☐ F 66 Director 30,1945 266-74-7051 Jan. Tennessee Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 and 2 should be filed within 72 hours after death with the Marylan 28a-f show 1 ☐Yes 2 XNo iral", or items 23a or 28a-f sl Ersmir at must be notified Director FL 0kaloosa Fort Walton Beach 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 60 Yacht Club Drive NE #12 32548 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □ Yes 2 □ XAo Specify. Specify: White <u>გ</u> 3 Widowed 4 Divorced "natural" Completed th and Mental Hygiene.
7 is marked other than "natuu traumatic event, Ire Medical 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SELF EMPLOYED Architectual Draftsman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Fred Charles Cooke Pamela Doris Jean Burr မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Pamela Scheel- Sister 652 Beal Parkway NW Unit G Ft. Walton Beach, FL 32547 item 27 other t 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 permit. Pages Department of Important: If it any injury or o 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State Atlantic Crematory 7/27/2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Miller-Dippel Funeral Home Signature of Funeral Service Licensee 6415 Belair Road Baltimore, MD 21206 Approximate Interval Between Onset and Death Part Enter the dise as or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, le Lilt only one cause on each line. Immediate Cause (Fin 1 rdiac Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Cervical Spondylosis with Myelopathy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CERTIFICATION APPROVED BY MEDICAL EXAMINER Physician/Medical Examiner attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐Yes 2 ☐No Month Day Year 5 ☐ Other (specify) certificate has been signed by the irector, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 No 2 No 1 □ Yes 1 ☐ Yes 25. Was case referred to medical examiner?
1 Yes 2 Yes funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 An Accident investigation within 24 hours after death To the Funeral Director: filled in by the 3 ☐ Suicide ould not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) och Raven Blod. 560 Andreu 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG O 1 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		State of Maryland / Department of Health and Mental Hygiene								
			Registrar 1. Decedent's Name (First, Middle, Le	Certificate of Death			NZUI	24356		
	Physicia		Tase M	F Contract	To	2. Date of Death Month	Day Year	3. Time of Death		
4. 4.	Medic Examir		4a. Facility Name (if not institution, give	e street and number)	4b. City, Town, or Location of Deatl	Jarya	4c. County of Death			
And the second	,		7964 Kara	mauch Road	Durdalk		Baltim	CRE		
	Funeral Director			Sex 7. Age (In yrs. last I	birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea		place (State or Foreign		
	A		Usual Residence of Decedent			1-14-1	78.5	7100		
	yland -f sho ed at	ţ	10a. State 10b. County		own or Location			10d. Inside City Limits		
	or 28a	Director	10e. Street and Number	RORE DIL	10f. Zip Code	10-	0777	1 Yes 2 No		
	with the	Funeral	7964 Kavar	wayed Onad	21233	Tog.	Citizen of What Cou	ntry ?		
	death items ier mu	Fu	11. Marital Status	12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - Americ			
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ary			19a. Informan 's Name/Relationship (9b. Mailing Address (Street and Number or Ru	ral Route Number, City	or Town, State, Zio	Code)		
	and 2 s Health s tem 27 i		Joseph E CON	way TIT SON	8602 Quentin Ave	Baltin	ore n	821234		
Baltimore,	0		20a. Mether of Disposition 1 Description 3	Removal from State 20b. Place	e of Disposition (Name of etery, crematory or other place)		. Location - City or To	own, State		
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Ba	permit, Departr Importa any inju	ķ	21. Signature of Eunoral Service Licer	see	22. Name and Address of Facility	radley-1	ASKTON F	inveral		
			23a. Part 1. Enter the disease, or cor shock, or heart failure. List only	opplications that caused the death. Do	o not enter the mode of dying, such as cardiac	or respiratory arrest,	pzins Kel	Approximate		
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0 00	nding tth. : After e fune	cate	1 ✓ Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day, Year)	injury	28d. Describe how in	jury occurred			
Division of Vital Records,	r Atter	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home,	farm, street, factory, office	28f. Location (Street		Route Number,		
á	Hospital 4 hours Funeral ted filled	alc		building, etc. (Specify) City or Town, State)						
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only one) 3 Certifying Nurse Practioner: To the best of my knowledge, seath occurred at the time, date and place, and due to the cause of the country of the best of my knowledge, seath occurred at the time, date and place, and due to the cause of the country of the best of my knowledge, seath occurred at the time, date and place, and due to the cause of the country of the best of my knowledge, seath occurred at the time, date and place, and due to the cause of the country of the best of my knowledge, seath occurred at the time, date and place, and due to the cause of the country of the best of my knowledge, seath occurred at the time, date and place, and due to the cause of the country of the best of my knowledge, seath occurred at the time, date and place, and due to the cause of the country of the best of my knowledge, seath occurred at the time, date and place, and due to the cause of the country of the best of my knowledge, seath occurred at the time, date and place, and due to the cause of the country of t							se(s) and manner as stated. Date signed (Month, Day, Year)			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last, 2. Date of Death Physician/ Month Year 0:20Fh 10. Medical Name (if not stitution, give street and number, 4c. County of Death Examiner 4b. City, Town, or Location of Death 7. Age (In yrs. last birthday, 8. Date of Birth place (State or Foreign **Funeral** 9 Ri 1 □**X**M 2 □ F Months Days Min 01-26-1933 Unknown **Director** 258-48-3931 Yrs 78 Usual Residence of Decedent 28a-f show 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Lexington Park Md. 1 H Yes 2 No St. Mary's 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 20653 U.S.A. 21412 Great Mills Road items ? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. ò 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 XNo Specify: Specify: Black "natural" 3 X Widowed 4 Divorced event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Unknown Unknown Unknown Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 other tra 1717 K Street, NW Suite 600 Washington, DC 20036 Arnettia S. Wright - Conservator 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20c. Location - City or Town, State cemetery, crematory or other place)
MD Veterans Cemetery 08-10-11 1 XBurial 2 Cremation 3 Removal from State Cheltenham, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service 22. Name and Address of Facility Ronald Taylor II Funeral Home 0583 Middleport Lane, White Plains, Md. 20695 28a. Part 1. Enter the disease, of complications that caused shock, or heart failure. List only one cause on each line. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): cate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy 5 Other (specify) Month Day Year Pregnant at time of death Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 Y No 3 ☐ Probably 4 ☐ Unknown After this certificate has been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an prior to comp death? autopsy Yes 2 No Yes . Was case referred to medical examiner? completed filled in by the funeral director, 26. Place of Death (Check only one) Hospital Other: ၀ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending 1 X Natural 1 Yes 2 No Accident Investigation n 24 hours after deat e Funeral Director; 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 29d, Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) GREAT MIlls Rd. State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ OUMBIR 2011 BABU Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOLY CROSS PRING MONTGOMER HOSPITA Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) MI 1 □ M 2 🛛 F (Month, Director Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No SILVER SPRING MONTGOMER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 40 PO 700 PIKE OLD COLUMBIA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Bace - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: 3 Widowed 4 Divorced -QCK BL Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) life. DO NOT use retired) College (1-4 or 5+ Elementary/Seconday (0-12) NFANT NEANT N Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ MAHAMADOU FOUNDATA DOMMBIR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CROSS HOSPITA 200 FOREST COLEN 82 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Cother (Specify) in State cemetery, crematory or other place, 22. Name and Address of Facility State Anatomy Board g, we of Funeral Service Licentee Ronal of S Din 655 W. Baltimore St; Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death ock, or heart failure. List only one cause on each line Immediate Cause (Final disease or con in n resulting in death) Ph sician/ EXTREME PREMIATURIT Medical Due to (or as a consequence of) Examiner MATERNAI Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) anding physician and use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death 1 Yes 2 L 9 Unknown ed by the g Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Tes 2 No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\subseteq \text{ Yes} \) 2 \(\subseteq \text{ No} \) 24a. Was an After this certificate has I funeral director, page 2 s autopsy 1 Yes 2 No Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital 2 No မ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) nin 24 hours after death.

the Funeral Director: After thi

npleted filled in by the funeral or 27. Mann of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural iniury 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check within 2 To the F only one 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

10313

GEORGIA

AUE

SPRING MD 20902

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signat

amend #19a Per FH G918 8/05/2011 Jh
State of Maryland / Department of Health and Mental Hygien [2] | | 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ .Montl Year P M 806 LANDICE AWANGE 2011 Medical Facility Name (if not institution, give street and number) Examiner 4b, City, Town, or Location of Death 4c. County of Death Burnic Anne ltimore hington Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Virginia 6. Sex. 8. Date of Birth **Funeral** Days 1 - M 2X-XF Months Hours 217-56-4455 09-26-1949 Director 61 Yrs Usual Residence of Decedent or 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland the Medical Examiner must be notified at Director 1 Yes 2 No MD Millersville Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a (by Funeral 8231 Sherbrooke Court 21108 United States 'natural", or items death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black White etc. 1 Never Married 2 X Married Yes 2 X No hours after 1 Yes 2 No Specify: If Yes Give Specify: Completed 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) within 72 Maryland 2121 permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any finury or other traumatic event, the Megonee. Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Administrative Assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Lois Faith Slaughter Alvin Rudolph Wilkerson 9a Informant's Name/Relationship (*Type, Print*) **John Wayne Dunaway–Husband** Wayne Danaway husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8231 Sherbrooke Court, Millersville, MD 21108 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5XXOther (Specify) Entombmen Meadowridge Mem. Pk. 08-01-2011 Elkridge, Maryland 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility Gary L. Kaufman Funeral Home at MMP, Inc, 7250 Wash. Blvd., Elkridge, MD 21075 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) NEUROFNDOCRINE MONTH S Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Examiner Due to (or as a consequence of) physician and s the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as attending IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No as been signed by the atter Day Pregnant at time of death 1 ☐ res ∠ ∠ ☐ Unknown a 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 X No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available 24a. Was an has prior to completion of cause of death? autopsy page performed? Yes 2 No 24 hours after death. Funeral Director: After this certificate by 1 ☐ Yes 2 🔀 No 25. Was case referred to medical funeral director, æ 26. Place of Death (Check only one) examiner? Hospital 2 🔀 No Other: 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending Accident Investigation 3 Suicide 4 Homicide within 24 hours after dex To the Funeral Director completed filled in by th 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Dertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D64307 MI) 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID MD 301 HOSPITAL DRIVE GLEN BURNIE 20161 31. Date filed (Month, Day, Year) State 32. Registrar's Signature Registrar 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. 24360 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ John Gerard Dallman AM 20 Medical 4a Facility Name (if not institution, give street and number) **Examiner** or Location of Death 4c. County of Death If Under Social Security Number 8. Date of Birth (Month Day, **Funeral** Age (In yrs. last birthday) 9. Birthplace (State or Foreign Min 1 X M 2 D F 219-16-8643 Mary Tand **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Catonsville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 709 Maiden Choice Ln. 21228 **USA** 12. Was Decedent Ever in U.S. Agned Forces?

1 Yes 2 No If Yes, Give WW I Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, ≥ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Midowed 4 Divorced Completed WW II Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Electrical Engineer IBM Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Dallman Phoebe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maureen Bauer (Daughter) 12222 Apache Tears Circle, Laurel, MD 20708 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Sacred Heart of Jesus 7/28/11 1 X Burial 2 Cremation 3 Removal from State Dundalk, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Loudon Fark Funeral Home 21. Signature of Funeral Service Lice 3620 Wilkens Ave., Baltimore, MD 21229 23a. Parl - Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final infaration Onset and Death Ph_sician/ myocard. disease or condition resulting in death) WENDER Medical Due to (or as a consequence of): Examiner Secure fielly list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of): use as the burial-trans that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be f yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death

Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Year n signed by the and ld be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾| 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 Yes 2 No 25. Was case referred to medical B 26. Place of Death (Check only one) examiner? 1 🗆 Yes 2 🔀 No ျင 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) After this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes Accident 2 🗌 No Investigation 6 Could not be Director: Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or Att within 24 hours after do To the Funeral Direct completed filled in by the state of the Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number , vnp 1747353 July 24, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

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Baltimore

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Baltimore,	Page 1 tment of tant: If it jury or o		4 Donation 5 Other (Specif	y)	Most Holy	Redeemer Ce	metery 8-	-2-11		e, Maryland
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Ω	To the Hospital or Atte within 24 hours after de To the Funeral Directo completed filled in by th	Medical		siclan: To the best of m						as stated. the cause(s) and manner stated.
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, Mar Id 2 shou salth and	n 27 is m er traum	1	19a. Informant's Name/Relationship Sylvia Gibson			19b. Mailin	g Address (Street a	nd Number or Run d St Apt	41 7; Ba	er, City or Town, altimore	State, Zio B , MD	21218
balkimore, Maryland 21213-0036 permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.	ant: If iten ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 🖾 Other (Soc	☐ Removal from State		netery, crem	sition (Name of natory or other place	e)	Date	20c. Location	,	Town, State
permit. Depart	Import any inj once,		21. Signature of Funeral Society Lice Lice ROTIa Lo. S.	instald Diffe	ector	22	Name and Addres	_{s of Facility} Sta Baltimore				21201
			23a. N. rt 1. Enter the disease, or co shock, or heart failure. List only Immedia Cause (Final	emplications that caused one cause on each line	d the death. e.	Do not ente	r the mode of dying	g, such as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death
	edical		disease or o ition resulting in death)	a. Hepatic Du to (or as	a conseque	nce f):	alopath	y.			_	7 days
Exan	miner	er	Sequentially list conditions,	b. Acute	isch	eni	c stro	ke-			_	5 days.
cuted	ransit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events	С								
be exec	sician a burial-t	<u>8</u>	resulting in death) Last	Due to (or as	a consequer	nce of):						
oo/ou ertificate b	ing priy as the	Medi	IF FEMALE:									
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and	s been signed by the attending physician and should be detached for use as the burial-transit	Physician/Medic	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal o	death 3 🗌	Ectopic pregnanc Other (specify)	y		I .	ate of deliventh	very Day Year
s that the	gned by	by PI	Part II. Other significant conditions			0	, 0					the cause of death?
cords, aw require: as been sir	should	leted	contante Rational	tract ble	, rep	au	abotal	ma allita	1 L 24a. Was			opsy findings available
The law	ate nas page 2	Completed by	hypertension	, orace be	eary	g, a	imens	mean	auto perfo	psy prmed?	prior to codeath?	ompletion of cause of
VILAI ysician: s certific	rector,	Be	25. W s ase referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:			Lau	ice of Death (Chec	k only one)			
OIV ng Phys	neral di	te: To	1 ☐ Yes 2 ☑ No 27. Manner of Death 1 ☑ Natural 5 ☐ Pending	1 Inpati 28a. Date of inju (Month, Da	ent 2 🗆 Ef	R/Outpatien 8b. Time of injury	t 3 DOA 28c. Injury	at Nursing Ho		dence 6 Oth now injury occur		fy)
VISION or Attendir fter death.	by the fu	Certificate:	2 Accident Investigat 3 Suicide 6 Could no	ion t be 28e. Place of Inji	ary - At hom		M 1 🗆	Yes 2 No			per or Run	al Route Number,
pital or ours afte	filled in		29a. Certifier 1 Certifying P	building, etc		dan danth o	acured at the time	dete and place of	City or Tov		nor an stat	tod.
the Hos nin 24 hu the Fun	ine run	Medical	(Check 2 ☐ Medical Exa only one) 3 ☐ Certifying N	miner: On the basis of e urse Practioner: To the	xamination a	and/or investi	igation, in my opinio	n, death occurred a	t the time, date a	and place, and du	ue to the ca	ause(s) and manner stated.
To t	2 00		29b. Signature and title of certifier	MBBS			29c. License			29d. Date signs		
			30. Name and address of person wh		eath (Item 2	3a) (Type, P		5-000		JULY	27	, 2011
				UR, MBB		SINA	HOSP	ITAL OF	BALT	IMORE		
Re	Stat egistra		31. Date filed (Month, Day, Year) AUG 0 1 201	32, Registra	ar s Signatur	par						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Marylar		artment of H tificate of D		Mental Hy	2011	24363
			Registrar 1. Decedent's Name (First, Middle, Last,			inoute of E	- Cutii	2. Date of De	Reg. No. U I I	3. Time of Death
	Physicia Medic		Grenone 1	Grerha	10/	Se		Month /	1 38 20	
	Examin		4a. Facility Name (if not institution, give s		1	4b. City, Town, or	Location of Deat	1	4c. County of D	
-			7246 Groue	1 Street		Balt	MORE		Balt	THORE
	Funeral		5. Social Security Number 6 S	7. Age (In yrs. I		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir	14 4 1	Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	M 2 F 4	Yrs.			Month, Da	71943	PAD
	nd how at	<u>ا</u>	10a. State 10b. County	10c. Cit	y, Town or Lo	cation			/	10d. Inside City Limits
	laryla 3a-f s ified	Director	MD Balter	noef 1	16	200-				1 ☐ Yes 2 ☑ No
	or 28		10e. Street and Number	po ez	uell!	10f. Zip Code			10g. Citizen of What	Country?
	with s 23a ust b	Funeral	7246 Grau	h Street		212	24		USA	
	death item		11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?		Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (Sp n. Mexican, Puert	pecify Yes or No-	14. Race - A Black, W	merican Indian,
36	after I", or camir	l by	1 Never Married 2 Married	1 ☐ Yes 2 ☑ No If Yes, Give		☐ Yes 2 ☐ No		,	Specify:	/ /
21215-0036	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f show , the Medical Examiner must be notified at	Completed	3 Widowed 4 Divorced 15. Decedent's Ed	Year or Dates.	16a Docos	lent's Usual Occup	ation		16b. Kind of Busine	UNIR
15	~ c ₹	Ig II	(Specify only highest grad	le completed)	(Give I	kind of work done of NOT use retired)		king	166. Kind of Busine	ess industry
212	within 7; giene. ner than t, the Me		Elementary/Seconday (0-12)	College (1-4 or 5+)	e parameter	euck	DRIVER	2	E I KANE	office Movers
	e de E	Be (17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle	Maiden Surname)	
ylaı		မ	Greorge Gie	ahold			NIC	dred a	Frenhold	/
Maryland	shou and is m		19a. Informant's N e/Relationship (Typ	1	19b. Mailin	g Address (Street a	and Number or Ru	, 1	er, City or Town, State,	Zip Code)
	1 and 2 f Health item 27 other t		HNTHONY LONG-	Grand SON	202		nes Ra	,Ball	MORE	RID 21222
וסר	40 <u>4</u> <u>2</u>		20a. Method of Disposition 1 Burial 2 Cremation 3 1	Removal from State	emetery, cren	sition (Name of natory or other plac		Date	20c. Location - City	1
Baltimore,	permit. Page Department Important: I any injury o		4 Donation 5 Other (Specify,	y-17	ky to	Crema	tory 7	31-11	Gr/en Bi	UNIC MA
Ba	permit. Departr Imports any inju		21. Signature of Funeral Service License	e	1	L and Address	D a all	11/11/	1 - 175h	Dd 2,222
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	Ph_sician/		shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.	(- d	DON	nenti	•		Interval Between Onset d Death
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· rope	Examiner		Committee to the second second							
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760	physi the t	edical		d						
89	eath certificat attending ph for use as th	Ž/	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregna					23d. Date of	deliven
Box 687	atter for u	icial	in the past 12 months?	1 Live Birth 2 Feta 4 Pregnant at time of c		Ectopic pregnand Other (specify)	У		Month	Day Year
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COL	aw reas be	Jple	barken par	2000	20	/		24a. Was	psy prior	autopsy findings available to completion of cause of
Re	The l	Completed						1 🗆 Yes	ormed? death	h? Yes 2 1 No
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_	Phys	2	1 ☐ Yes 2 M No 27. Manner of Death	1 Inpatient 2	ER/Outpatien 28b. Time of	t 3 DOA 28c. Injury	4 ☐ Nursing I	1	dence 6 Other (S)	pecify)
n o	ding th. After fune	cate	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	injury	work	Yes 2 No	280. Describe	now rijury occurred	
Sio	Atten r dea ector by the	Certificate:	3 Suicide 6 Could not be	28e. Place of Injury - At ho					Street and Number or	Rural Route Number,
Division of Vital Records,	al or s afte	ပ္ပြ	4 - Horniode determined	building, etc. (Specify	•)			City or To	wn, State)	-
_	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completed filled in by the funeral director, page 2 should be detached for use as t	Medical	29a. Certifier 1 Certifying Physi (Check 2 Medical Examin	cian: To the best of my know	ledge, death o	ccured at the time	, date and place, a	and due to the ca	ause(s) and manner as	stated. the cause(s) and manner stated.
	the F the F the F		only one) 3 Certifying Nurse	Practioner: To the best of my	y knowledge, c	leath occurred at the	e time, date and pl	ace, and due to the	ne cause(s) and manne	r as stated.
	Nii Vo		29b. Signature and title of certifier			29c. License	number	54	29d. Date signed (M	2- 2-0 11
			30. Name and address of person who co	mploted agues of death #	222) (7: 7	rint)	00 T	7	01-20	2011
`			MALIKA WAS	SELM To	9. B	ASTER	N Bi	VD,	M-D - 2	3-2011 2-1221
	Stat Registra		31. Date filed (Month, Day, Year)	82. Registrar's Signar	bark	w				

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 24364 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month JULY 2011 DORA GORELIK 2:45 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 3211 CLARKS LANE, #321 BALTIMORE N/A . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) 1 □ M 2 🗓 F Months Min. Director (Month 137/1932 217-23-3577 79 **BELARUS** Usual Residence of Decedent ms 23a or 28a-f shov must be notified at 10b. County 10a. State filed within 72 hours after death with the Maryland 10c. City. Town or Location Director 10d. Inside City Limits 1 X Yes 2 ☐ No MD N/ABALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a Examiner must be Funeral 3211 CLARKS LANE. #321 21215 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Armed Forces? 1 ☐ Yes 2 ☐ No Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 XNo Specify: "natural", 3 ▼ Widowed 4 □ Divorced Specify: WHITE Year or Dates other traumatic event, the Medical 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working Page 1 and 2 should be filed within 73 ment of Health and Mental Hygiene. ant: If item 27 is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ TEACHER EDUCATION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 AVRAM GAVLIN ELIZABETH SLAVINA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LEN GORELIK/SON 12815 GORES MILL ROAD, REISTERSTOWN, MD 21136 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 A Burial 2 Cremation 3 Removal from State injury or cemetery, crematory or other place. Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) 07/29/2011 CHEVRA AHAVAS CHESED RANDALLSTOWN, MD Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or fleart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ plastic Medical resulting in death) Due to (or as a consequence of) Examiner veors Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of). or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury the attending physician and the for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Pivision of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 Other (specify) Pregnant at time of death 5 Month Day Year 1 Yes 2 Unknown Yes 2 No 9 Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performed certificate Yes 2 No 1 🗌 Yes 2 💢 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 힏 1 🗌 Yes 2 X No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this Certificate: Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1
Yes 28d. Describe how injury occurred X Natural 5 Pending injury Accident Investigation 6 Could not be 2 No after death Director: Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Funeral C Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie within 2 To the F only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

32. Registrar's Signature

Rutland Ave

ROSS Bldg.

TANVIKA GIBBS Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene **UNK UNK** 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day July 26, 2011 7 bbc 0719 hrs Medical Examiner nYIKA 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death NIM Bayview Hospital 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24Hrs. 5. Social Security Number **Funeral** oreign Country) Hours Min Director 36 7-07 mol. 1 M 2 V F Usual Residence of Decedent 10d Inside City Limits 1 Yes 2 No ma. Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygene.

ant: If them 27 is marked other than "natural", or items 22a or 28a-f sho or other tramanic event, the Medical Examiner must be notified at once. Director 10e. Street and Number 10g. Citizen of What Country? USA 4301 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Black. Armed Forces? 1 Never Married 2 1 Yes 2 V No stack If Yes, Give Year or Dates: 1 Yes 2 No specify: 3 Widowed 4 Divorced 2 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) NA Baltimore, MD 21215-0036 12 ch 18.Mother's Name (First, Middle, Malden Surname) 17, Father's Name (First, Middle, Last) Barbara Ann RAY 19a. Informant's Name/R-lationship (Type, Pri t) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 114 Straight St. Apt 5H Paterson AUNT artilla 20b. Place of Disposition (Name of cemetery. 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 Burial 2 Cremation 3 Removal from State MT. Zun Donation 5 Other Specify. 6 22. Name and Address of Facility 3405 W. Franklu gnature of Funeral Service Lice walla Approximate Interval Part I. E fir the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. It only one cause on each line /Medical a, Contact Gunshot Wound of Head Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit The law requires that the death certificate be executed Physician/Medical \boxed{x} AMENDED 28a-b, per me, g919 9-19-11 sm UNPENDED attending physician for use as the burial -Division of Vital Records. P.O. Box 68760, IF FEMALE: 23c. If ves, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the 2 Fetal death 3 Ectopic pregnancy Live birth Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≦ 1 Yes 2 No 3 Probably 4 Unknown Completed has been s 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? 1 ✓ Yes 2 No 2 No 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical uneral director, Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: Scene 1 Yes 28a. Date of Injury Jul 26, 2011 28c. Injury at Work? 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death Subject shot 0640 hrs 1 Natural 1 Yes 2 V No Pending - death Director: found found Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City within 24 hours after d 3 Suicide Could not be or Town, State) 4301 Nicholas Avenue, Baltimore, MD (Specify) rowhome determined 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number July 27, 2011 O.C.M.E.

State Registrar DHMH 17 Rev 1/2001

OCME 2006

Registrar's Signature

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

Russell Alexander MD. 31. Date filed (Month, Day, Year)

900 W. Baltimore Street, Baltimore, MD 21223

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Danner Alberta Harris Jul 2011 4:54 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A BALTIMORE SINAL HOSPITAL OF BALTIMORE CITY Social Security Number If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 6. Sex Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 M 2 D F Months Hours April 16, Year 23 Country) Maryland 88 424-36-2026 Director Usual Residence of Decedent 28a-f shov 10d. Inside City Limits the Maryland 10a. State 10c. City, Town or Location injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No N/A Baltimore MD 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? with t Funeral items 23a 21215 **USA** 4119 Elderon Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc. 0 1 Never Married 3 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: Black "natural", 3 Widowed 4 M Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) MVA Tags & Title Clerk 6th Grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Bessie Lee Miller Willie Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Heatth ar Important: If item 27 is any injury or other trau 4119 Elderon Avenue Baltimore, Maryland 21215 Veronique Harris - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 W Burial 2 Cremation 3 Removal from State Woodlawn, Maryland 7/30/2011 King Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) Chatman-Harris Funeral Home Baltimore, MD. 21206 21. Signature of Funeral Service Licenses 22. Name and Address of Facility le 4210 Belair Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death METABOLIC Immediate Cause (Final DelDOSIS Physician, disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner HYOPTEN STON Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Due to for as a consequence of sician and burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician I for use as the buria Physician/Medical or Attending Physician; The law requires that the death certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 5 Other (specify) Pregnant at time of death ned by the a Unknown P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 Yes 2 No 3 Probably 4 Unknown Completed should I 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page 2 this certificate 1 Yes 2 16 1 Yes 2 4 Division of Vital 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 🗌 Yes 2 **N**O 1 Inpatient 2 🗆 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Mann of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After injury 1 Natural 5 Pending Accident Investigation the 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examines: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P 26493 JULY 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BRIJEN JOSHI HOSPITAL OF BALTIMORE SINAL State

Registrar

HARRIS, DANNER

3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #13tate of Maryland? Department of Health and Mental Hygiene 20 | 24367

rillarii Otedari		1-For State Certificate Certif			2 U I I	24001
Physic Medical Exam		Decedent's Name (First, Middle, Last)		2. Date of Deat Month July 24, 20	Day Year	3. Time of Death 1617 hrs
		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of		4c. County of Death	
Funeral		4211 Byers Street 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Capitol Heights If Under 1 Year If Under	24Hrs. 8. Date of Birt	Prince George h(MM/DD/YYYY) 9. Bin	hplace (State or
Director		217-44-9335 1 M 2 F 64 Y	Months Days Hours	Min. 01/23	/1947 Foreig	untry) Wash, DC
W any		10a. State 10b. County 10c. City, Town or Loc MD Prince George's Cap	pitol Heights			10d. Inside City Limits 1 X Yes 2 No
faryland 28a-f show Lat 00cc.	Director	MD Prince George's Cap 10e. Street and Number	10f. Zip Code	10	g. Citizen of What Cour	
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. I file may 15 an arried other than "natural?, or items 23a or 28a-f sho nor other trannatic evect, the Medical Examiner must be onlifted at occe.		4211 Byers Street	20743		USA	
death wi or items	Funeral		Vas Decedent of Hispanic Origin Yes, specify Cuban, Mexican, F		14. Race - Ameri White, etc.	can Indian, Black,
rs after (ural", o	à	3 Widowed 4 Divorced If Yes, Give Year 1 or Dates:	Yes 2 X No specify:	nd of work done	Specify: Wh.	ite
5 72 hour n "nata	eted	Elementary/Secondary (0-12) College (1-4 or 5+)	most of working life, DO NOT us		New Carrol	lton
-003(l within giene. ther tha	Completed	12 Trucl 17. Father's Name (First, Middle, Last)	k Driver	Name (First, Middle, M	City Govern	nment
ID 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic evect, the Medica	Be	Stanley Derrick Hurtt			Fleury Mac	Donald
p, MD 21215-0036 and 2 should be filed within 72 hours after teath and Mental Hygiene. To a marked other than "matural", fraumantic evect, the Medical Examiner fraumantic evects.	ြို		ing Address (Street and Numb S. Reynolds St			
Baltimore, MD permit. Pages I and 2 sh Department of Health an Important: If item 27 is lojury or other traumat			osition (Name of cemetery, other place)	Date	20c. Location - City or	
Baltimore, permit. Pages I ar Department of Hee Important: If ite		4 Donarion 5 Other Specify:		08.01.2011	Hanover,	
Balti permit. Departu Importi		Mu Wu 4	Name and Address of Facility Ohn L. Williams 517 Park Hgts 2	s Funeral I Ave Baltimo	Directors, increase, MD 212	P.A. 15
Physician /Medical		23a. P.M. Enter the disease, or complications that caused the death. Do not enter future. List only one cause on each line.				Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Hypertensive Atherosclerotic Card Due to (or as a consequence of):	diovascular Disease Col	mplicated by Hyp	erthermia	Deau
	er	Sequentially list conditions, if eny, leading to immediate b. Due to (or as a consequence of):				
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
xecuted 1 and - transit	al E	d				
60, ate be exe ohysician a	Medical	UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery	
Box 687(e death certifica the attending ple ed for use as the	cian/	23b. Was decedent pregnant in the past 12 months?	Fetal death 3 Ectopic p	pregnancy		ay Year
BOY ne death the att	Physician/	1 Yes 2 No 9 Unknown 9 Unknown				
P.O.	δ	Part II. Other significant conditions contributing to death but not resulting in the Chronic alcohol abuse	underlying cause given in Part		pacco use contribute to t	
ords, w requir is been s should	Completed			24a. Was a autops	y prior to c	opsy findings available ompletion of cause of
Reco	Com			perform 1 ✓ Yes 2	ned? death? !☐No 1 ✔ Ye	s 2 No
/ital /siciae: uis certi:	Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatier	26.Place of Death (C		Residence 6 🗸 Other	Scene
Division of Vital Records, tale or Attending Physicies: The law requir as fare death. In Director: After this certificate has been seled in by the funeral director, page 2 should 1	on: To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Warner of Death	Finjury 28c. Injury at Work?	28d. Describe h	ow injury occurred osed to hot environ	
isior Attencer death	icati(2 Accident Investigation Jul 24, 2011 1530 hrs 28e. Place of Injury - At home farm, str	1 Yes 2 ✓ N	temperatures		
Div pital or ours aft filled in	Certification:	Suicide Could not be determined (Specify) Single Family Home		or Town, St		
Division of Vital Records, P.O. Box 68760, To the Hopital or Attending Physiciae: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	29a. Certifier (Check only one) 2 ✓ Medical Examiner: On the basis of examination and/or investignand manner stated.				
T W C	Me	29b. Signature and title of certifier	29c. License number		29d. Date signed (Mon	th, Day, Year)
		30. Name and address of person who completed cause of death (Item 23a)	O.C.M.E.		July 25, 2011	
		Melissa Brassell, MD Assistant Medical Examiner 900 V		timore, MD 2122	3	
S Regis	tate trar	31. Date filed (Month, Day, Year) AUG 0 1 2011 August 32: Registrar's Synature August 32: Registrar's Synature August 32: Registrar's Synature	1			

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amend #20a-c Per FH G918 8/01/2011 JH
State of Maryland / Department of Health and Mental Hygiene
1- State Amend Item 25 per me, g918,08/18/2011dhb
Registrar

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State Of Maryland / Department of Health and Mental Hygiene
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State Of Maryland / Department of Health and Mental Hygiene
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 24368 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician/ 0655AM 2011 Johnson Annie JUL Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** BALTIMOR NA SINAI HOSPITAL OF BALTIMIA If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral 10-12-Days Min Country) 1 □ M 2XOXF SC 249-42-8050 80 Director Usual Residence of Decedent 10d. Inside City Limits or 28a-f show notified at 10b. County 10c. City, Town or Location 10a. State Baltimore, Maryland 21279-0036 JOH 050 e filed within 72 hours after death with the Maryland Director XX Yes 2 No Gwynn Oak MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō "natural", or items 23a or edical Examiner must be Funeral USA 21207 3647 Campfield Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11 Marital Status Black, White, etc. African þ 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No If Yes, Give 1 ☐ Yes 2X No Specify. Specify: American ¾XWidowed 4 □ Divorced Completed Year or Dates is mar ed other thar "natur aumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 12th Grade College (1-4 or 5+) Kemet Electronics Machine operator Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Annie Mae bruner Grady Brown permit. Page 1 and 2 should e Department of Health and Msn Important: If item 27 is mar e any injury or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2120719a. Informant's Name/Relationship (Type, Print) 3647 Campfield Road Gwynn Oak, Maryland Rev. Don. Johnson-Son 20c Location - City or Town, State 20a. Method of Disposition Date 20h Place of Disposition (Name of Representations) + K Burial 2XX Cremation 3 Removal from State reenville, 08-06 -11 Rest Haven Gem. 4 Donation 5 Other (Specify) Wylie Funeral Home I.A. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee MD 21217 638 N. Gilmor Street Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final HEMORRHAGE NTRA Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of): CERTIFICATION APPROVED BY THE Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by TENJION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🎾 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an his certificate has but director, page 2 sh autopsy performed 1 Yes 2 No 2/0 No 1 🗌 Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? 1 X Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ Inpatient 2 ER/Outpatient 3 DOA After this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 7333 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL OF BALTIMORE SINAI 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 0 1 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death KOPP **Physician** 0846 AM EORGE 2011 14/4 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CiTY N/A HOPKINS BALTIMORE HOSPITAL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1**⊠** M 2□ F 217-60-4149 Yrs. 58 Director 8-12-1952 MARYLAND Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show is marked other than "natural", or items 23a or 28a-f shor raumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☐No Director ROSEDALE MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21237 U.S.A. 1300 DORIS AVENUE Funeral hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 __Yes X___No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No If Yes, Give Year or Dates: Specify. Completed by Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry filed within 72 h 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) REFINISHER MOOD 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 12 should be fi th and Mental H permit. Pages 1 and 2 should b. Department of Health and Mente Important: If item 27 is marked any Injury or other traumatic evonce. (Sadilek) MARGARET JOSEPH KOPP DOLORES **GEORGE** 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21156 UPPER FALLS, MD MARY ELLEN EMERY/SISTER P.O. BOX 8 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 Cremation 3 Removal from State 7-30-2011 CATONSVILLE, 4 □ Donation 5 □ Other (Specify) METRO CREMATORY 22. Name and Address of Facility CVACH / ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Licensee 21237 1211 CHESACO AVE ROSEDALE, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final EMBOLISMS **Physician** DUIMONARY disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CELI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-transi Due to (or as a consequence of): the attending physician hed for use as the burial P.O. Box 68760, Physician/Medical as, IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 □Yes 2 □No s been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð 2 No 1 Tes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ■ Yes 2 □ No 24a. Was an has page 2 autopsy performed certificate Yes 2 No Hospital or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner: 1 X Yes 2 ☐ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) After this c funeral dire 1 Nnpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation neral Director: A 2 Accident 1 ☐ Yes 2 ☐ No death. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide after within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier KEJ-BOOD 28,201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) um

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

AUG 01

ORIGINAL

32 Registrar's Signature

			1 – For State Registrar	State of Ma	ryland /		irtment o <i>tificate d</i>				ien é. U I eg. No.	ı	24370
	Physici	an	1. Decedent's Name (First, Middle, Las	t)						2. Date of Deat Month July		Year I I	3. Time of Death
1	/Medic		Patrick Wayne Ke						(5 "	July	_		5:35 A M
	Examin	ner	4a. Facility Name (If not institution, give	ŕ				n, or Location Market			4c. County o	of Death deri	
·*	Funeral		-	ex 7. Age	(In yrs. last t	oirthday)	If Under 1 Ye	ar If Under		8. Date of Birth	1600	9. Birth	place (State or Foreign
	Director		5. Social Security Number 6. Se 215-88- 215-88- 9895 11	M 2□F	41	Yrs.	Months Da	ys Hours	Min.	8. Date of Birth (Month, Day Iarch Id	, 1970	Nor	th Carolin
	pug w		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Lo	ation					11	10d. Inside City Limits
	Aaryle f sho	ō	MD Frede	rick		Mark							1 ☐ Yes 2 🖺 No
	r 28a-	rec	10e. Street and Number				10f. Zip Cod			1	0g. Citizen of W	hat Cou	ntry?
	h with	a D	190 Wicomico Dr	•			2177	74			USA		
0000	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatilb and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, I'm Medical Evair instruible incitifs of anone.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ∐Yes 2 ☑ N If Yes, Give Year or Dates:		"	Vas Decedent i Yes, specify (Cuban, Mexica	in, Puerto F	cify Yes or No- lican, etc.)		White,	
2	72 ho	eted	15. Decedent's Ed (Specify only highest grad	ucation	16	a. Deced	lent's Usual Oc	cupation	st of warkin	0	16b. Kind of Bus	siness/In	dustry
7	ithin ne. han "	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	+)		kind of work do OO NOT use re	tired)	50 01 WOTHIT	9	aana	+****	ction
7	iled w Hygie ther t nt, th	ပ္ပ	12 17. Father's Name (First, Middle, Last)	0		тар	orer	18 Moth	er's Name	(First, Middle, I	Maiden Surname		, cron
	d be f ental ced of	o Be	Vernon Lewis Kee	ner							cheimer		
Mary	nd 2 shoul lith and M 27 is marl r traumati	욘	19a. Informant's Name/Relationship (7 Mary Pat Keener		19						; City or Town, S Maryla		
illore,	Pages 1 ar nent of Hea int: If item iry or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☒ Donation 5 ☐ Other (Specify		20b. Place ceme	of Dispos tery, cren	sition (Name or natory or other	place)	Da	ate	20c. Location - 0	City or To	own, State
Dalillio	permit. Departn Importa any inju		21. Signature Funeral Service Licens	Bir	ector	22					omy Boar timore,		21201
	Physician /Medical Examiner	er.	23a. Parl 1. Enter the disease, or compshots, or heart failure. List only of limmediate use (Final disease or condition resulting in death) Sequentially list conditions,	ilications that caused one cause on each line a	e. AR() consequence	10/ e of):	NEO PER		s cardiac or		est,	,	Approximate Interval Between Onset and Death
,00,00	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 burus after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a									
. C. BOX 0	the death certiff yy the attending ached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome c 1 □ Live birth 2 4 □ Pregnant at 9 □ Unknown	2 🗌 Fetal dea		Ectopic pregn				23d. Date Mor		very Day Year
L (SD)	quires that in signed t	þ	Part II. Other significant conditions or	ntributing to death bu	t not resulting	in the ur	derlying cause	given in Part	l.	23e. Did to	5.0	ibute to t 3 □Pro	the cause of death? bably 4 ☐ Unknown
ו טבינו	The law reate has bee page 2 sho	Completed	-							24a. Was a autops perform	ned? d	rior to co <u>ea</u> th?	opsy findings available ompletion of cause of 2 □ No
2	cian: ertific ictor,	Be (25. Was case referred to medical examiner?						e of Death	(Check only on			
5	hysion this call dire	၉	1 Yes 2 No	<u>_</u>	nt 2 ER/0		1 3 DOA				ence 6 □Othe		ify)
	Jing F	ioi	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day)	Year) 285	. Time of injury		njury at Vork? 1 □Yes 2 □		8d. Describe he	ow injury occurre	ed	
	II or Attene after death Director: d in by the	ertification:	2 Accident investigation 3 □ Sulcide 6 □ Could not be 4 □ Homicide determined	28e. Place of Injuition	ry - At home, (Specify)	farm, stre	-2.4			8f. Location (Si City or Town	treet and Numbe n, State)	er or Rur	ral Route Number,
	he Hospita n 24 hours ne Funeral oletely fille	edical C	29a. Certifier 1 Certifying Phyone) Certifying Phyone Medical Exam	rsician: To the best o iner: On the basis of and manner stat	examination :	ge, death and/or inv	occurred at the	ne time, date a my opinion, de	and place, a	and due to the co	eause(s) and ma late and place, a	nner as and due	stated. to the cause(s)
	To the within the complete of	Me	29b. Signature and title of certifier	Moso				ense number 330 &		2	9d. Date signed		
			30. Name and address of person who of the property of the control	ompleted cause of de	ath (Item 23a 4 <i>30 R</i>	OCK	Print)	DR.	BETT	tESDA,	MD 3	1081	7
	Sta Registra	te ar	31. Date filed (Martin Can Year) 201	3 Registra	r's Signature	pa	Nes						

DHMH 17 Rev 1/2001

11-05	575
Aaron	Kevs

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Aaron Keys 1- For State	State of Maryla	and / Department o	f Health and Mental f Death	Hygiene Reg. No.	2011 24371
Medical Examiner Coro				2. Date of Death Month Day July 26, 2011	Year 3. Time of Death 0503 hrs
4a. Facility Nam Sinai Hos	e (if not institution, give street and nu pital	umber)	4b. City, Town, or Location of De Baltimore	eath 4c	: County of Death
Funeral Director 5. Social Securit 2/3-/3	-4/338 1 MM 2 F	7. Age (In yrs. last birthday) 35 Yrs		#Hrs. 8. Date of Birth(MM/ Min. //-//-/9	BC State or Country)
the Maryland Oirector Oi	Ba/Amore Number	10c. City, Town or Locat	0-11	10g. Citi	10d. Inside City Limits 1 ☐ Yes 2 ☑ No zen of What Country?
after death with age of the man and the m	Arried 2 Married Armed Fr 1 Yes 4 Divorced If Yes, Give Yes or Dates:	orces? If Y 2 No 1	is Decedent of Hispanic Origin? fes, specify Cuban, Mexican, Pu	erto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black
Elementary/Se	Education (Specify only highest gradecondary (0-12) College (1) College (1) College (1)	during m	It's Usual Occupation (Give kind ost of working life. DO NOT use new plants of the life of		Unemoloyed Surname)
AD 21215 Should be fill and Mental F St is marked matter event, 1 To Be To Be	Name/Rela nsh (Type, P/t)	19b. Mailing	g Address Street and Number	or Rural Route Number, Ci	nn Davis ity or Town, State, Zip Code) 34 03 C Cockey (5 Ville MD
Time of the part o	Disposition Cremation 3 Removal fr Disposition Cremation 3 Removal fr Disposition Full Service Licensee	rom State Crematory or other	Zion 8	Date 20c. 1 8-1-2011 E	Sa / Limore, MD The Fineral Services
Physician 23a. Part I. Erite	the disease, or complications that conly one cause on each line.	aused the death. Do not enter t	728 Liberty A	Road, Randa	115 town, MD 21133
Immediate Caus or condition results from the second	ulting in death) Due to (or as a b. b. immediate Due to (or as a b. Due to (or as a conditions, or immediate)	unt Force Injuries a consequence of):			
if any, leading to cause. Enter Ur (Disease or injure events resulting events resulting UNPENDE	y max iniciated	a consequence of):			
DE CELLIFICATION OF THE PROPERTY OF THE PROPER	23c. If yes, ont pregnant in the ths?	nant at time of death 5 Ot	tal death 3 Ectopic pre		d. Date of delivery Month Day Year
O. C. Part II. Other sig	gnificant conditions contributing to	o death but not resulting in the u	inderlying cause given in Part I.		use contribute to the cause of death? No 3 Probably 4 Unknown
tal Records, P.O. Box tian: The law requires that the death corrificate has been signed by the arte corrier has been signed by the arte correct has been signed by the arte correct has been signed by the arte correct has been signed by the arte correct has been signed by the art				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
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oo the Hospi of the Hospi oon pletely function (Checky only 1 (Checky only 1 one) 2 (Checky only 1 one) 2 (Checky only 1 one) 2 (Checky only 1 one) 2 (Checky only 1 one) 2 (Checky only 1 one) 2 (Checky only 1 one) 2 (Checky only 1 one) 2 (Checky only 1 one) 3 (Checky one) 3	Certifying Physician: To the bes Medical Examiner: On the basis and manner s	of examination and/or investigat	ion, in my opinion, death occurre	and due to the cause(s) and ed at the time, date and pla	ce, and due to the cause(s)
29b. Signature at	nd title of certifier	A profesth (Hem 23a)	29c. License number O.C.M.E.		Date signed (Month, Day, Year)
	lexander MD. Assistant M		W. Baltimore Street, Bal	OCME	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend#17perfng918 8-1-11 d.o. State of Maryland / Department of Health and Mental Hygiene Reg. No. 201 24372 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month [Year Physician/ KNOX 10.45 AM mest 20/1 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard County Howard County General Hospital Columbia 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 **X**M 2 □ F Months Director 428-22-0799 Mississippi Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 X Yes 2 No Md. Howard Ellicott City 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? Funeral 21043 5138 Morningside Lane U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Black, White, etc. by 1X Yes 2 □ No If Yes, Give Year or Dates. 1942–1945 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: nan "natural", Medical Exan Specify: Black 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Ith and Mental Hygiene. 27 is marked other than "r r traumatic event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) Barber Self-Employed 9th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Knox Pollie Hatchett Samuel -Knav 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5138 Morningside Lane, Ellicott City, Md. 21043 Paula Gary - Daughter permit. Page 1 and 2 Department of Healtl Important: If item 2 any injury or other t injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 08-01-2011 Owings Mills, Maryland Garrison Forest Cem. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ronald Taylor II Funeral Home e of Funeral Service Licer 10583 Middleport Lane, White Plains, Md. 20695 Put 1. Enter the disease, complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or plach line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): nding physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 the IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day 5 Other (specify) Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 XUnknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N 2**X** No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2 X No. ျာ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Mann Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Accident Investigation within 24 hours after death To the Funeral Director; 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of eep 29d. Date signed (Month, Day, Year) 29c. License number 1648 24 2011 MI Va who completed cause of death (Item 23a) (Type, Print) - 10710 Charter Drive Suite 310 Columbia, Md. 21044 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 20 1 24373 State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		,		Certific	cate of	Death			J	Reg. No.		
Physicia Medical Exami				e,Last)							Date of De Month	ath Day	Year	3. Time of Death
A A	1101	4a. Facility Name (if i		n, give street and n	ımber)		4	o. City, Town	or Location	of Death	July 25, 2		ounty of De	2109 hrs
J.		Conowingo R	Road at M	erry Knoll Lane	•			Conowing	go			Ce		
Funeral		5. Social Security Nu	mber	6. Sex	7. Age (In	yrs. last bi	rthday)	If Under 1 Months [Year If Und	der 24Hrs.	8. Date of B	irth (MM/DD	/YYYY) 9.	Birthplace (State or preign
Director		212-19-682		1_XM 2_F	3	4	Yrs.	IVIOTILIS	Days Hour	S IVIIII.	04/20)/1977		Country) PA
la la		Usual Residence of D 10a. State 10	Decedent Ob. County		10c.	City, Town	n or Locatio	n						10d. Inside City Limits
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72 hours after death with the Maryland n "natural", or items 23a or 28a-f she all Examiner must be netitled at once	Funeral	11. Marital Status 1 X Never Married		12. Was Dec		in U.S.	13. Was	Decedent of s, specify Cu	Hispanic Ori	igin? (Spe	cify Yes or N	0- 14	. Race - An	nerican Indian, Black,
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filed v Hygi		17. Father's Name (Fi		Last)						- 1-1	First, Middle,			
212 Jid be Menta marke	To Be	James P. 19a. Informant's Name		nip (Type, Print)		I 19	b. Mailing A	Address (St		_	J. Ra			tate, Zip Code)
AD 2 show h and 27 is matting	-	James P. K												Land 21911
Te, Tand I and Healt Fitem	- 1	20a. Method of Dispo-	sition			20b. Place	of Dispositi	on (Name of	cemetery,		Date			or Town, State
Pages sent of	İ	4 Donation 5		3 Removal fr			Ferri			07/2	28/2011	West	Ches	ster, PA
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatie event, the Medical Examiner.		21. Signature of Fune							ess of Facilit	Func	ral Ho	mos E	Σ Δ	
	_	23a Part I, Enter the	discolor or a	amplications that a		#- D	401	S. Ch	<u>rester</u>	Stre	et Bal	timor	e, Ma	aryland 21231
Physician /Medical		failure. List only	one eduse o	on each line.		eath. Do n	ot enter the	mode or ayır	ng, such as c	ardiac or i	espiratory an	rest, shock,	or heart	Approximate Interval Between Onset and
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6870 ertifica ling ph		23b. Was decedent pre past 12 months?	gnant in the	1 Live b	irth			death	3 Ectopio	c pregnanc	су	Mo	ate of deliv inth	Pery Day Year
Box 68 e death certif the attending ed for use as	Physician	1 Yes 2 No	9 Unkn		ant at time o	of death	5 Othe	r (Specify)				9		- 1
Division of Vital Records, P.O. Box 68: the Hospital or Attending Physician: The law requires that the death certiff hin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending upletely filled in by the funeral director, page 2 should be detached for use as I		Part II. Other significa	ant conditio			not resultin	g in the und	lerlying caus	e given in Pa	art I.	23e. Did to	obacco use	contribute	to the cause of death?
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r Attend r Attend ter death irector: n by the		2 Accident 3 Suicide 6	Investi	28e Place	of Injury - A	At home, fa	arm, street,	factory, office			Bf. Location (\$	Street and N	Number or f	Rural Route Number, City
Divis	Certification	Suicide 6 4 Homicide	determ	HOLDE	Roadwa						or Town, S onowingo R	tate)		
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To the within 2 To the complet	ᄝ	one) 2 Me		iner:On the basis of and manner st		on and/or i	nvestigation			curred at ti	ne time, date			
	2	29b. Signature and the	or certifier	11 .11.1					nse number					fonth, Day, Year)
	-	JAMAN (30. Name and/address	of person	to completed care	e of death /	Item 22a)		1	,.tv1. ∟.			July 26		
D		Pamela E. So				,	r 900 V	V. Baltimo	ore Street,	, Baltim	ore, MD 2	1223		
Sta		31. Date filed (Month, L	Day, Year)	32. Re	gistrar's Sig	nature								
Registr	_	אטט ט	<u> </u>	Charma	<u> </u>	1	Keel	-	-					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Veronica Priscilla Lee 8:00 AM 29 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford 718 Nottingham Drive Aberdeen Social Security Number 8. Date of Birth (Month, Day, Year April 23 9. Birthplace (State or Foreign Country) MD If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2**X** F Months Days Hours 219-70-0374 Yrs ,1956 55 **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Harford Aberdeen 1 Yes 2 XNo MD 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral USA with 718 Nottingham Drive 21001 permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner m Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc þ 1 X Never Married 2 ☐ Married ☐ Yes 2 X No altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify Completed 3 Widowed 4 Divorced Black Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Warehouse Laborer unknown Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Doris J. Calloway Whitney Lee, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 718 Nottingham Drive Aberdeen, MD 21001 Mother Doris J. Calloway/ 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial XXCremation 3 Removal from State Department of Important: If any injury or once. Greenmount Cemeterly 7/27/11 Baltimore, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Funeral Service Licensee 4210 Belair Road Baltimore, MD 21206 . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_sician/ cardiac arre disease or condition resulting in death) 01.129/201 Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): nding physician and use as the burial-transit I or Attending Physician: The law requires that the death certificate be executed after death. Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 1 Live Birth
4 Pregnant
9 Unknown ρģ Month Day Year Pregnant at time of death the detached 9 Unknown After this certificate has been signed by funeral director, page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Syndowne 2 No 3 ☐ Probably 4 ☐ Unknown Downis 24b. Were autopsy findings available prior to completion of cause of Hypothy ro dom autopsy perform death? 1 Yes 2 No 2 No To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DCA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Man r of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 🗌 Yes Natural 5 Pending injury 2 🗌 No Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined the Hospital 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and title of certifier 29d, Date signed (Month, Day, Year) 27,2011 MO DO063610 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 103 A Bata B MD 2101 Pegistrar's Signature State

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Registrar

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			For	State of M	aryland		artment of H		Лental Ну	giene		01075
			State Registrar			Cer	tificate of D	eath		Reg. No		24315
	Physicia Medic		1. Decedent's Name (First, Middle CLA)	LAN LAN	DRY				2. Date of Dea Month		20 Year	3. Time of Death
	Examin		4a. Facility Name (if not institution				4b. City, Town, or			4c, Coun	ty of Death	
	ct.		Johns Hopkins E			inter	Bo	altimo			N/A	
	Funeral Director		5. Social Security Number 215-40-6713	6. Sex 7. Ag	je (In yrs. last i	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day June 17	, Year) 1933	Coun	place (State or Foreign stry) achusetts
	nd how at	ŗ	Usual Residence of Decedent 10a. State 10b. County		10c, City, To	own or Loc	pation			_		10d. Inside City Limits
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	s 23a	Funeral	7331 Waldman	Avenue				212	219	Unit	ed Sta	ates
	death r item iner n		11. Marital Status	12. Was Decedent Armed Forces?		13. V	Vas Decedent of His Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ace - Americ	
336	al", o	d by	1 ☐ Never Married 2 🌠 Married 3 ☐ Widowed 4 ☐ Divorced	ied 1 ☐ Yes 2 X If Yes, Give Year or Dates.	No	1	☐ Yes 2 🌠 No	Specify:		Speci	fy:	White
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Maryland 21215-0036	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If it item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationsl Mr.: William J.				ng Address (Street a					Code) 21219
	permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 2 once.		20a. Method of Disposition		20b. Plac	e of Dispo	sition (Name of	-	Date	20c. Location		
mo	Page nent o ant: If iny or		1 ☐ Burial 2 ፟፟፟፟ Cremation 4 ☐ Donation 5 ☐ Other (5				natory or other place Service		1/2011	Towso	n, Ma:	ryland
Baltimore,	permit. Departn Importa any inju once,	l i	21. Signature of Funeral Service L	icensee	20	22 Du	. Name and Addres	s of Facility Funeral I	Home of	Dunda1	k, Inc	c.
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	Physician/ Medical		shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	nly one cause on each lin	ER G	ASTR	COINTES					Interval Between
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Sion	Attendaria deati	Certificate:	2 Accident Investi 3 Suicide 6 Could 4 Homicide determ	not be 28e. Place of Inj	ury - At home	, farm, stre	eet, factory, office	163 2 1110			nber or Rura	I Route Number,
N	ital or Insafte ral Dire			building, et					City or Tow			
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 Medical E	Physician: To the best of examiner: On the basis of Nurse Practioner: To the	examination an	nd/or invest	igation, in my opinio	n, death occurred a	it the time, date a	ind place, and	due to the ca	ause(s) and manner stated.
_	vithi To the	-	29b. Signature and title of certifier		-		29c. License			29d. Date sign		
			30. Name and address of person	who completed cause of	leath (Itam 22	la) /Tupo E		3922		/ [100	2011
			Gio ROW G	AUCTO M			4940 EC	istern	Avenu	e, Ba	1timos	e, md, 21224
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DHMH 17 Rev 7/2009

BILLY LOVITT 11-05579 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unk Unk State of Maryland / Department of Health and Mental Hygiene 2011 24376 1- For State Certificate of Death Ragistrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day July 26, 2011 **Medical Examiner** 0730 hrs 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Baltimore** 4301 Nicholas Avenue 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign Country) Days Director Hours Min. 154-44-3421 1 YM 58 11-17-1952 2 F Carolina Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 Yes 2 No other than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at once. Baltmore md. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 4301 Nicholas Ave Funeral 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 1 Yes Black 4 Divorced If Yes, Give Year or Dates: 3 Widowed 1 Yes 2 No specify: ğ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Bradway Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27, in marked other than 'in jury or other tranmatile event, the Medical in jury or other tranmatile event, the Medical in Driver 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Elizabeth Be James C ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cartilla Louit Paterson, SISTER 5/ raight St. Apt 5H 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State con Donation 5 Other Specify: 22. Name end Address of Facility 3405 gnature of Funeral Service Licensëe Papt. Enter the disease, or complications that caused the death. Do not enter the mode of lying, such as cardiac or respiratory failure yest only one cause on each line. Approximate Interval Between Onset and Physician /Medical a Multiple Gunshot Wounds Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit Physician/Medical AMENDED #28a,b,perME,G919,9/22/2011,WS e attending physician a for use as the burial -UNPENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 23d, Date of delivery 1 Live birth 2 Fetal death Day Month Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown hed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>≨</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed?

Yes 2 No death? 1 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 Other Nursing Home 5 Residence 6 🗸 Other: Scene DOA 1 🗸 Yes oeral Director: After t filled in by the funeral 28a. Date of Injury Jul 26, 2011 27. Manner of Death 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? Certification: Subject shot 1 Natural 5 Pending 0730° hrs 1 Yes 2 ✔ No Found 2 Accident Investigation within 24 hours after de To the Fuoeral Direct completely filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) 4301 Nicholas Avenue, Baltimore, MD 4 Momicide determined (Specify) Rowhouse 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Sal 2 📝 Medical Examiner: On the basis of examination-ent/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c License number 29d, Date signed (Month, Day, Year)

• 6

31. Date filed (Month, Day, Year)

Russell Alexander MD.

and address of person who completed cause of death (Item 23a)

32. Registrar's Signature

Assistant Medical Examiner

OCME

July 27, 2011

State Registrar O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
amend#20a,b,c 22 perfn g918 8-4-11 d.o.
State of Maryland / Department of Health and Mental Hygiene
amend item 1 per doc g918 8-10-11 vt
Certificate of Death
Reg. No. 2 1 1 For State Registrar 1. Decedent's Name (First, Middle, Last, Charles Myers 2. Date of Death Physician/ 2:05 AM Medical 4a. Facility Name (if not institution, give street and number)
Loch Roven Community Livin Examiner 4b. City, Town, or Location of Death 4c. County of Death Community Living Cente Battimore Social Security Numbe If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday, 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 X M 2 □ F ug 20, Months Days Hours Min. **Director** 1940 Maryland 213-36-7132 70 Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21229 USA 121 N. Monastery Ave. within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: black 1 ☐ Yes 2 X No Specify. If Yes, Give 3 Widowed 4 X Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should e filed within 75 Department of Health and Mental Hygisne. Important: If item 27 is mar led other than any injury or other traumatir event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 0 1ongshoreman ship yard Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Arthur Myers Doris Henson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6606 Copper Ridge Dr; Balto, MD 21209 Charles Arnold Myers - son 20b. Place of Disposition (Name of cemetery, crematory or other place)

Garrison Forest 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Otney (Specify) Owings Mills MD 08/08/11 Ponald S Ware 22. Name and Address of Facility Joseph H. Brown Fun Home PA 2140 N. Bathiron ave; Barted MD 21277 21201 23a. Left 1. Enter the disease, or complications that caused shows, on heart failure. List only one cause on each line. Immediate cause (Final ications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Stage ancer Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year signed by the a d be detached f 1 Yes 2 9 Unknown Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has be lirector, page 2 s autopsy performed 2 No 1 Yes Division of Vital funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE ည 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28c. Injury at 28b. Time of 28d. Describe how injury occurred After Natural 5 Pending
Investigation work's n 24 hours after death.

Funeral Director: Aft
oleted filled in by the fun 1 Yes 2 No Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier completed (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the only one 29b. Signati re_and title of certifier 041365 2011 who completed cause of death (Item 23a) (Type, Print) 3 9 00 30 Name and address of person Kaven oule altinue AUG 0 1 State Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend 31 perdbrg 918 8-1-11 d.o. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 3:10p Mildred Inez Morse July 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A 5028 Pembridge Ave Baltimore Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) MD Year) 1922 March Day 217-12-6896 89 Hours Director Usual Residence of Decedent 10b. County N/A than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at 10a. State MD 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director Baltimore Y☐ Yes 2 ☐ No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5028 Pembridge Ave 21215 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12, Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 ₩Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiens Important: If item 27 is marked other than ", any injury or other traumatic event, the Mag once. Baltimore City life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Public Schools N/A Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Sarah Green 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lawrence G. Morse, Jr/Son 8409 Church Ln. Randallstown, MD 21133 20c. Location - City or Town, State 20b. Place of Disposition (Name of cometery, crematory or other place 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Eugeral Service Licepsee 22. Name and Address of Facill 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Breact inclienancy Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consequence of, sician and burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) Po in the past 12 months?
1 \(\subseteq \text{ Yes} \) 2 \(\subseteq \text{ No} \) Month Day Year the page 2 should be detached g 🗌 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 No this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 🗌 Yes ပ 4 Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After to ompleted filled in by the funeral Natural Accident 5 Pending 1 🗌 Yes 2 🗌 No Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier (Check 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) M7 1143386 7-27-11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Howard, 41 Daniel €405 RalLimore

State

Registrar

Echin

31. Date filed (Month, Day, Year)

7-27-11

32. Registrar's Signature

no

2120

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ CHARLES Day McCORMICK Year 12 50 AM 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FRANKLin Square Hospital Rosedale Baltimore Social Security Number 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ₺ M 2 🗆 F 218 22 2359 Months Days Hours Min. **Director** 84 MARYLAND Usual Residence of Decedent er than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director MD BALTIMORE PHOENIX 1 Yes 2 X No 10f. Zip Code 10g. Citizen of What Country? Funeral 3010 PAPER MILL ROAD 21131 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married If Yes Give 1 ☐ Yes 2 X No Specify. Specify: WHITE Completed 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) 4 ACCOUNTANT GENERAL BUSINESS Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ HERBERT McCORMICK MAUDE Α. TRAVERS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a RUTH SUMMERS/ DAUGHTER Department of Health Important: If item 27 any injury or other tr 1418 PEPPER AVE BALTIMORE, MD 21237 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 1 Burial 2 Cxcremation 3 Removal from State METRO CREMATORY 7/29/2011 BALTIMORE, MD 4 Donation 5 Other (Specify) permit. 21. Signature of Funeral Sevice Licensee 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE BALTIMORE, MD 21237 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ difficile colitis Clostridium disease or condition WEEK Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) sician and burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an • Hospital or Attending Physician: The law 24 hours after death.
• Funeral Director: After this certificate has I autopsy performed 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ည 1 Inpatient 2 ER/Outpatient 3 DOA Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) MO STEELS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 FRANKLIN Square 21237 Laura Stee DR Balto State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene T = For State Registrar Certificate of Death Reg. No 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ MADELINE CATHERINE CALLAN McNICHOLAS :50P Julv Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death EDENWALD RETIREMENT COMMUNITY Towson Baltimore County If Under 5. Social Security Number 7. Age (In vrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 👿 F Months Days Hours Min. (Month, Day, 94 Director 216-44-3837 Maryland Dec Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Examiner must be notified at Director Maryland Baltimore County Towson 1 Yes 2 No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Funeral 23a 21286 800 Southerly Road USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Force Black, White, etc. ö þ 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after. Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examir 2 💢 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Federal Internal Elementary/Seconday (0-12) Analyst Revenue Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John Gordon Callan Anna Louise Chlan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul C. Callan (Brother) <u>719 Maiden Choice Lane, HR429</u> Catonsville, MD 21228 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 7/29/2011 Holy Redeemer Cemetery Baltimore, Maryland 4 Donation 5 Other (Specify, 21. Signature & Fungral Service Compace HELL WIEDEFELD FUNERAL York Road, Baltimore, HOME INC Maryland 21212 Martin D. Lawson 6500 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirate shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and ath Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Dequentially not conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnar 23d, Date of delivery in the past 12 month 1 Yes 2 No 3 Ctopic pregnancy
5 Other (specify) Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 □ Probably 4 □ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an perform 25. Was case referred to predical æ 26. Place of Death (Check only one) examiner? Hospital: Other: ᅙ 1 Tyes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 \square Pending atural Accident work? 1 ☐ Yes 2 ☐ No in 24 hours after occ....he Funeral Director: Aft Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 🛣 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 3 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item) 2 30. Name and address of pe

Registrar

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GOOD SAMPRITAN HOSPITAL, 5602 Lock Ravon Rlvd. Baltimore, MD, 21239

11-05617 Judith P. Mandell

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2011 24382
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar				Certifica	ate of L	Death		,	R	Reg. No	o		
Physicia Medical Examir		1. Decedent's Name (First, Midd JUDITH	e,Last)	IAM	NDEL	L					2. Date of Dea Month July 27, 2	Day	Year		3. Time of Death 1431 hrs
		4a. Facility Name (if not institution 301 Hornel Street	n, give st	treet and num	nber)			City, Town, or Baltimore	Location	of Death	·	4	c. County o	f Death	
Funeral		5. Social Security Number	6. Sex	7	'. Age (In	yrs. last birt	hday)	If Under 1 Year		er 24Hrs.	8. Date of Bi	irth (MN		9. Birt	hplace (State or
Director		045-34-9478	1 M	2 <u>X</u> F	6	8	Yrs.	Months Days	Hours	s Min.	01/0	7/1	943	Foreig	MMECTICUT
an y		Usual Residence of Decedent 10a. State 10b. County			10c.	City, Town	or Location								10d. Inside City Limits
. 8	٦	MD	N/A			BAL	гімон	RE							1 XYes 2 No
Maryland 28a-f show d at once.	Director	10e. Street and Number					11	Of. Zip Code		_		10g. Ci	tizen of Wha	at Coun	itry?
th the Maryland 23a or 28a-f sho notified at once,		301 HORNEL							224					.s.	
hours after death with the Maryland natural", or items 23a or 28a-f sh Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 M	arried 1	2. Was Deced	ces?			ecedent of His specify Cuban				0-	14. Race - White,		can Indian, Black,
after de	J.	3 Widowed 4 X Div	orced If	Yes, Give Year	2 X 1	No	1 Y	es 2X No	specify:				Specify:	HI	TE
hours hours Exami	eg	15. Decedent's Education (Spe	cify only I					Usual Occupat of working life.				16b.	Kind of Bus	iness/Ir	ndustry
5-0036 led within 72 hou Hygiene. other than "nat	Completed	Elementary/Secondary (0-12) 1 2		College (1-4	or 5+)		AC	SENT				l _R	EAL :	EST	ATE:
5-003(led within Hygiene. lother tha the Medic		17. Father's Name (First, Middle,	Last)						18.Mother	's Name (First, Middle,				
21215-4 nuld be filed with the marked oth	<u>~</u> [UNKNOWN 19a. Informant's Name/Relations			RODE		Mailing A	ddress (Stree	VI	OLE	r UN	KN		State	Zin Codo)
MD 21215-0036 12 should be filed within 7 th and Mental Hygiene. 27 is marked other than umatic event, the Medica	의	RANDY MANDE		SON		1.7		AIRMOU						_	1037
	ı	20a. Method of Disposition 1 Burial 2 X Cremation		Pernoval from	n State	0b. Place o		n (Name of cen			Date		Location -		
Baltimore, permit. Pages 1 a Department of He (mportant: If its nijury or other tr		4 Donation 5 Other St	ecify:		II State	BAYV		CREMAT			9/11	BA	LTIM	ORE	, MARYLAND
Baltimo permit. Page Department or Important: injury or ott	1	21. Signatur	Licensee			M	22. Nam	ne and Address LLY &)1 EAS'	of Facility	ER :	INC. H	FUN	ERAL	НО	ME
Physician	+	23a. Part I. Enter the disease, or			sed the d	eath. Do no	1 19 (t enter the) 1 EAS mode of dying,	TERN such as c	AV ardiac or	ENUE , I respiratory arr	$rac{BAL}{L}$ rest, sh	TIMO lock, or hea	RE,	Approximate Interval
/Medical		failure. List only one cause Immediate Cause (Final disease			Athero	sclerotic	Cardiov	ascular Dis	ease						Between Onset and Death
-xammer		or condition resulting in death)	Due	e to (or as a c	onsequen	ce of):									
	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due	e to (or as a co	onsequen	ce of):									
	Examiner	(Disease or injury that initiated events resulting in death) Last	c. Due	e to (or as a co	onsequen	ce of):								- 1	
760, icate be executed physician and the burial - transit			d												
760, icate be executed sphysician and the burial - transi	Medical	UNPENDED					,G918	,8/1/20	11,W	S		Los	1 5-4	-11	
5876 artificat ling ph		IF FEMALE: 23b, Was decedent pregnant in the past 12 months?	e 1	23c. If yes, ou 1 Live birt	h	2	Fetal	death 3	Ectopic	pregnan	су	23	d. Date of d Month	D:	ay Year
Box 68's death certificate at the attending ed for use as t	Physician	1 Yes 2 No 9 V Unk	nown	4 Pregnan 9 Unknow	nt at time o m	of death 5	Other	(Specify)							
		Part II. Other significant conditi	ons co	ntributing to d	leath but r	not resulting	in the und	erlying cause g	iven in Pa	art I.		_			he cause of death?
S, P.C uires that n signed	ed by									_					ably 4 🗸 Unknown
cords law requi	Completed										24a. Was autop		pri		opsy findings available ompletion of cause of
tal Rection: The certificate ector, page	[_		_	_		OC Plans	-f D#-	(Check or	1 Yes	2 V N		Yes	s 2 No
Division of Vital Records, tal or Attending Physician: The law require rs after death. al Director: After this certificate has been side in by the funeral director, page 2 should be	o Be	examiner?	Hosp	pital: 1 Inp	atient 2	ER/Ou	tpatient 3			•	Home 5	Reside	ence 6 🗸	Other:	Scene
ing Ph	-1	27. Manner of Death		28a. Date of (Month, D	Injury ay,Year)	28b. T	ime of Injur	y 28c. Injur	y at Work	? 2	8d. Describe				
Sior Attend death ector:	ĕ	Pend	ing tigation	28a Diago	of Injury	At home for	tt 6		es 2		Of 1	04	and Niverban	D	al Davida Number City
DIVI spital or , tours after acral Dir	Certification:		not be mined	(Specify)	or injury -	At Home, rai	III, Street, I	actory, office bu	allollig, et	·. 2	or Town, S		and Number	or Rura	al Route Number, City
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Pt						at the time, da							
To the Hos within 24 h To the Fur	교	one) 2 Medical Example 29b. Signature and title of certifie	an	n the basis of e d manner stat	examinati ed.	on and/or in	vestigation	in my opinion,		curred at f	the time, date				
		hy w frida		uthall				O.C.N					/ 29, 201		th, Day, Year)
	ŀ	30. Name and address of person				Item 23a)									
		Pamela E. Southall, M	D A	ssistant M			900 V	/. Baltimore	Street	, Baltim	ore, MD 2	1223			
Sta Registr	-	31. Date filed (Month, Day, Year) AUG 0 1 2011	h	32. Regis	strar's Sig	nature	20								
DHMH 17 Rev 1/20 OCME 2006	01		1001		1	ORI	GINAL					ОСМ	E		

		-	For State Registrar		Cer	tificate of L	Death		Reg. N	0.	
	Physicia Medic		1. Decedent's Name (First, Middle, Last) Stephen J. Malar	nowski				2. Date of De July 2		011 Year	3. Time of Death 10:50 PM M
es and	Examin		4a. Facility Name (if not institution, give stre Genesis Homewood Co			4b. City, Town, o	r Location of Death		40	c. County of Death	
Ī	Funeral Director		5. Social Security Number 6. Sex 214–18–7946	7. Age (In yrs. las	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi	rth 4 921	g. Birthp Mary	place (State or Foreign
	Maryland 28a-f show otified at	Funeral Director	Usual Residence of Decedent 10a. State 10b. County Maryland N/A	10c. City, Balti	Town or Loc						0d. Inside City Limits 1 🏿 Yes 2 □ No
	with the s 23a or ust be n	eral D	10e. Street and Number 1538 Shadyside Road	đ		10f. Zip Code 21218				itizen of What Cour Led State	•
9800	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No If Yes, Give Year or Dates.	1	Vas Decedent of H Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	-	14. Race - Americ Black, White, Specify: Wh	
1215-(ithin 72 hor ene. • than "nat he Medica	Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Seconday (0-12)	Completed) College (1-4 or 5+)	(Give k	O NOT use retired)	ation during most of worki	ing	1	Kind of Business In	•
Baltimore, Maryland 21215-0036	I be filed with the filed with the fire of the fice of the fice of the fice of the fice of the fire of	To Be (17. Father's Name (First, Middle, Last) Anthony Malanowski				18. Mother's Name Rosalie I		, Maider		
, Mary	nd 2 should ealth and N n 27 is ma er trauma		19a. Informant's Name/Relationship (Type, Helen Malanowski /	<i>'</i>			and Number or Rura Road Balt				
timore	Page 1 al tment of H tant: If iter jury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Rei 4 ☐ Donation 5 ☐ Other (Specify)	moval from State Cel	netery, crem ntic (sition (Name of natory or other place Crematory	7 07/28,		Balt	Location - City or To	aryland
Ball	permit Depart Impor any in	1	1. Signature of Funeral Seylic-Vicensee	M	- 1			-			Homes PA land 21231
-	Physician/ Medical		23a. Part 1. Enter the disease, or complica shock, or heart fallure. List only one commediate Cause (Fifal disease or condition resulting in death)	ause on each line.		r the mode of dyin	g, such as cardiac c	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Examiner	e.	Sequentially list conditions, b.	Due to (or as a conseque		<u> </u>					
	ecuted and -transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events c resulting in death) Last	Due to (or as a conseque							
8760	tificate be executed ng physician and as the burial-transit	Medical E	d.								
	ig ge	Physician/Me	IF FEMALE: 23c 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No g Unknown	. If yes, outcome of pregnand 1 ☐ Live Birth 2 ☐ Fetal 4 ☐ Pregnant at time of de g ☐ Unknown	death 3 🗌	Ectopic pregnand Other (specify)	су			23d. Date of deliv Month	ery Day Year
	uires that th r signed by ild be detac	by	Part II. Other significant conditions contri	buting to death but not resul	Iting in the u	nderlying cause gi	ven in Part I.			use contribute to the	ne cause of death?
Division of Vital Records,	has has	Completed						24a. Was auto perf 1 \(\sum \) Yes	opsy ormed?	prior to co death?	psy findings available mpletion of cause of
Vital	ician: certific rector,	To Be (25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	pital: 1 ☐ Inpatient 2 ☐ E	B/Outpatien	LOth	er: 4 Nursing Ho		idence	6 ☐ Other (Specify	()
on of	or Attending Physician: ifter death. irector: After this certific in by the funeral director,	Certificate:	27. Mann of Death Natural 5 ☐ Pending 2 ☐ AccidentInvestigation		28b. Time of injury	28c. Injur work	y at	28d. Describe			
DIVISI	al or Atters after de al Directo		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, stre	eet, factory, office		28f. Location City or To		nd Number or Rura e)	Route Number,
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director, After this completed filled in by the funeral di	Medical	(Check 2 Medical Examiner:	n: To the best of my knowled On the basis of examination a ractioner: To the best of my k	and/or invest	igation, in my opini	on, death occurred at	t the time, date	and plac	e, and due to the ca	use(s) and manner stated
	To t To t		29b. Signature and title of certifier	M-D.		29c. Licens	Α.			ate signed (Month,	Day, Year)
FI			30. Name and address of person who com	oleted cause of death (Item 2	23a) (Type, P	204, F	70076	lle, n	NO-	21254.	
	Stat Registra		31. Date filed (Month, Day, Year) AUG 0 1 2011	32. Registrar's Signatu	re feet	2					

11-05618 Casimir Mazur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2011	24	38	-
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		I-For State Registrar		Ce	rtificate	e of De	ath			Reg. N		U :	1 2430
Physicia Medical Exami	ın/	1. Decedent's Name (First, Middle,Last) 2. Date of Dec								Death Day		Ü	3. Time of Death 1730 hrs
		4a. Fecility Name (if not institute 245 South Ellwood Av		umber)			y, Town, or Itimore	Location of	Death		4c. County of	f Death	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/I Days Hours Min. 07/01/195										Foreig	hplace (State or n untry) Germany
any	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Insid									10d. Inside City Limits		
Aaryland 28a-f show Lat once.	ö	Maryland N/	A	Bal	timor		Zip Code						1 Yes 2 No
ith the Maryland 23a or 28a-f sho notified at once	Director	10e. Street and Number 245 S. Ellwood	Avenue								itizen of Wha Inited		
er death w	Funeral	11. Marital Status 1 X Never Married 2 M 3 Widowed 4 Div		2 X No	l.S. 13	If Yes, spe	ecify Cubar	n, Mexican, F	n? (Specify Yes or Puerto Rican, etc.)	No-	White,	etc.	can Indian, Black,
ours after	d b	15. Decedent's Education (Spe	or Dates:			cedent's Usu		tion (Give kir	nd of work done	16b	Specify: . Kind of Bus	Wh:	
5-0036 led within 72 hours aft: Hygiene. other than "natural" the Medical Examine	Completed	Elementary/Secondary (0-12)		1-4 or 5+)				. DO NOT us	se retired)	Ci	tr. Cor	7020	amont
5-00; ed with tygiene other th	E S	17. Father's Name (First, Middle	+4 , Last)		ACC	ounta	nt T	18.Mother's	Name (First, Midd		ty Gov n Surname)	veri	Illeric
21215-0036 vald be filed within 7 Mental Hygiene. marked other than ic event, the Medica	8	Mikolaj Mazur			1				Kusznir				
MD 21215-003i d 2 should be filed within th and Mental Hygiene. n 27 is marked other the	٩	19a. Informant's Name/Relations John Mazur - F			100				er or Rural Route nue Balti		-		
Baltimore, MI permit. Pages 1 and 2 s Department of Health a Important: If item 27	Ī	20a. Method of Disposition 1 X Burial 2 Cremation			Place of D	isposition (N	Vame of ce	metery,	Date	200	Location - 0	City or	Town, State
Baltimore, permit. Pages I an Department of Hea important: If itel	-	4 Donation 5 Other S 21. Signature of Funeral Service	pecify:	Sa		Heart terv 22. Name a			08/02/201	1 Ba	altimo	re,	Maryland
Perm Depa Lings		23a. Part I. Enter the disease							Funeral E	lomes 11tin	P.A.	Mar	vland 21231
Physician /Medical	9	failure. List only one caus	on each line.			nter the mod	de of dying,	such as can	diac or respiratory	arrest, s	hock, or hear	t	Approximate Interval Between Onset and Death
<i>Ξ</i> xaminer		Immediate Cause (Final disease or condition resulting in death)	a. <u>Cardiac</u> Due to (or as a	Arrhyt consequence o	hmia ^{f):}								
	5	Sequentially list conditions, if any, leading to immediate		negaly w		left v	entri	lcular	hypertr	ophy			
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	consequence o	of):							_	
recuted and transit			-1 d					212.0	2 11				
760, cate be executed physician and the burial - transi	Medical	▼ UNPENDED IF FEMALE:		.3a-b,pt outcome of preg		2/,per	me,g	918 8-	-3-11 sm	2	3d. Date of d	elivery	
Box 68760, death certificate b he attending physic d for use as the bur		3b. Was decedent pregnant in the past 12 months?	1 Live t		2	Fetal dea	th 3	Ectopic p	pregnancy	1	Month		ay Year
D. Bo	Physician	1 Yes 2 No 9 Uni	ons contributing t		esulting in	the underly	ing cause o	niven in Part	1 23e Di	d tobacci	o use contrib	ute to t	he cause of death?
P.C	d by	Schizophrenia										_	ably 4 🗹 Unknown
of Vital Records, of Physician: The law require ther this certificate has been sineral director, page 2 should be	Completed by									as an topsy rformed?	pri	or to co	opsy findings available ompletion of cause of
tal Rec	ဦ	25. Was case referred to medica			_		00 Pi	-6D#- (C	1 ✓ Y∈	s 2		ath? ✔ Ye:	s 2 No
Vital I hysician: this certifi	To Be	examiner? 1 Ves 2 No	- Hospital:	Inpatient 2	ER/Outpa	atient 3	DOA DOA		heck only one) Nursing Home 5	Resid	ience 6	Other:	Scene
도 등 : ^ 4		27. Manner of Death 1 X Natural 5 Pend		of Injury , Day,Year)	28b, Time	e of Injury	1 —	ry at Work? Yes 2 ☐ N	28d. Descri		njury occurred		
Division To the Hospital or Attendin within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	2 Accident Inves	stigation	e of Injury - At h	ome, farm,	street, facto			28f. Locatio		and Number	or Rur	al Route Number, City
DIVIS To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	흥	4 Homicide dete	rmined (Specify)				······		4	n, State)			
To the Ho within 24 To the Fu	G.	(Check only 2 Medical Exa	miner:On the basis	of examination a									
5 H & H	ŝ	29b. Signature end title of certifie	and manner s	tated.		2	29c. Licens	e number		29d	. Date signed	(Mon	th, Day, Year)
		Ceral	Heles	lav	_		O.C.I	M.E.		Jul	ly 28, 201	1	
		30. Name and address of person Carol Allan, MD As	who completed caussistant Medical	•	,	Baltimore	e Street,	Baltimore	e, MD 21223				
Sta Regist		31. Date filed (Month, Day Year)	111 2. Re	egistrar's Signa	ire	Wed							-

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 125AM 2011 0 Medical 4a. Facility Name (if not institution, give street and nun 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MARYLAND George shown Inton Birthplace (State or Foreign Country) Funeral 8. Date of Birth (Month, Day, last birthday If Under 24 Hrs Hours 1 □ M 2**X**□ F 578-78-4742 Director 53 Yrs. Wash. 08-04-1957 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. Counfy 10c. City, Town or Location 10d. Inside City Limits Director MD PG 1X Yes 2 □ No Temple Hills 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 3505 Dixon St. 20748 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian. ild be filed within 72 hours after of Mental Hygiene. Iarked other than "natural", or þ 1 Never Married 2 X Married 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: 3 Widowed 4 Divorced Specify: Black Completed Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Washington Court Hotel Elementary/Seconday (0-12) College (1-4 or 5+) Housekeeping Supervisor marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Leroy Driver Margaret Frazier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Geronimo McClanahan/Husband 3505 Dixon St. Temple Hills, MD 20748 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)

Mt. Olivet Cemetery 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 7-27-2011 Washington DC 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ronald Taylor II FH Signature of Funeral Service License 10583 Middleport Ln. White PLains, MD 20695 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph sician/ disease or condition Medical resulting in death) o (or as a consequence of): UNKNOWA Examiner moni Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year 9 Unknown Part II. Ather significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown Completed Atrial Ephillotron with Royil Rose 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy perform death? Yes Division of Vital 25. Was case referred to medica Be 26. Place of Death (Check only one) 1 Yes 2 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred eral Director; After filled in by the funer 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours a

To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 1162626 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar d DHMH 17 Rev 7/2009



NICHOLSONBROWN

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State of Maryland / Department of Health and Mental Hygiene amend #4a7Cper PHY & 19a&b Per FH G918 8/10/2011 JH 20 | Certificate of Death 24386 Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month odore 1900 2011 Medical 4a. Facility liam 6 not institution give street and number 4c. County of Death N/A Balto. **Examiner** Catonsville Baltimore VA Med 1000 8. Date of Birth Social Security Number Funeral 7. Age (In vrs. last birthday) If Under 1 Year I If Under 24 Hrs 9. Birthplace (State or Foreign Days Hours 1 🔀 M 2 🗆 F 0692347923 Maryland 215-18-9054 88 Director Usual Residence of Decedent 10c. City, Town or Location Catonsville permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County Baltimore 10a. State 10d. Inside City Limits Director 1 XYes 2 No MD N/ABaltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21228 U.S.A. 1016 Crosby Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian. Black, White, etc. þ 1 ☐ Never Married 2 🔀 Married 2 No 1X Yes Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: If Yes, Give 3 Divorced Completed Black Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) London Fog 6th Grade Cutter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maltilda Wright Theodore Maddox 19a. Informant's Name/Relationship (Type, Print) (wife) 19b. Mailing Address (Street and Number or FUzi tron grante). Lie or Town, State, Zip Code) Veronica Grady - Maddox 1016 Crosby Rd., Baltimore, MD 21228 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ty Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Owings Mills, MD 07/19/11 Garrison Forest 21. Signature of Funeral Service Licensee Joseph H. Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Dementia Vascular y ear disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner pars Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine pue to for as a consequence on attending physician and for use as the burial-transit the Hospital or Attending Physician: The law lequires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d Date of delivery in the past 12 months? Month Year Yes 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Congestive heart-fallenge Completed 1 ☐ Yes 2 ☐ No 3 🕱 Probably 4 ☐ Unknown circinary retention 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 X No Other: 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🕅 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🛛 Natural injury work? 5 Pending 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined City or Town, State) 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29c. License number 29d. Date signed (Month, Day, Year) 12011 R046221 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Balt, MD

Registrar

DHMH 17 Rev 7/2009

State

2. Registrar's Signature

Green Street BalfyAnd Center

21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 24387 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 30°- $\operatorname*{July}$ 201T 5:27 A. M Grace Arnold Nalls Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Gilchrist Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Feb. 1929 Months Days Hours Min Country Maryland 1 □ M 2 💢 F 213-28-4950 82 **Director** Usual Residence of Decedent 28a-f show 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location must be notified at Director 1 X Yes 2 No Maryland N/A Baltimore 10f. Zip Code 10g. Citizen of What Country? ò 10e. Street and Number 23a Funeral 5406 Willowmere 21212 U.S.A. Way items be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 X No the Medical Examiner Black, White, etc. ō 1 Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", Completed 3 Widowed 4 N Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Dental 5+ years event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be:
Department of Health and Menta
Important: If item 27 is marked
any injury or other traumatic ev. ည R. Miller Arnold Grace Stonebracker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chapel Court Timonium, Maryland 21093 Doris A. Martinet (sister) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Druid Ridge Cemetery 8-3-11 Pikesville, Maryland Mitchell-Wiedefeld Funeral Home 6500 York Road Baltimore, Mary 21. Signature of Funeral Service Licensee Joseph 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final 10 condial intara -Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Dusite (or as a nonsequence of): nding physician and use as the burial-transit Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after decth.

To the Funeral Director After this certificate has been signed by the attending physicis. P.O. Box 68760 use as IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No ò Day Year Month Pregnant at time of death be detached Unknown Part the Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Was an autopsy performed? 24a. Was an funeral director, page 2 Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 1 🗌 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending injury 1 Natural work?
1 Yes 2 No 2 Accident
3 Sulcide
4 Homicide Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

DHMH 17 Rev 7/2009

only one

29b. Signature and title of certifie

30. Name and address of person who

AUG 0

31. Date filed (Month, Day,

32. Registrar's

29c. License number 1)25205

Suppleted cards of death (Item 23a) (Type, Print)
Charles St. Bolto ind 21208

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Howard F. Naiditch	1- For State Registrar	tate of Maryla		ment of <i>icate of</i>		d Mental Hy	_	Reg. No. 2	01	1 2438	
Physician/ Medical Examiner	Decedent's Name (First, Middle HOWARD F		гтсн]:	2. Date of Dea Month July 26, 2	Day Y	ear	3. Time of Death 1925 hrs	
	4a. Facility Name (if not instituti 3601 Fords Lane, Ap	on, give street and nun			b. City, Town, or I	Location of Death		4c. Count			
Funeral	5. Social Security Number	7. Age (In yrs. last I	Age (In yrs. last birthday)			8. Date of Bi	rth(MM/DD/YY)	N/A YN 9. Bir	thplace (State or		
Director	217-54-9118	60	Yrs.	Months Days) For					
h	Usual Residence of Decedent 10a. State 10b. County		10c. City, Tov	um or Locati	nn		02/2/	7 1731		10d. Inside City Limits	
d how any	MD N/A		-	TIMOR						1 X Yes 2 No	
the Maryland a or 28a-f show tified at once. Director	10e. Street and Number		DAL	TITOR	10f. Zip Code		1	10g. Citizen of V	√hat Cou	ntry?	
h the N 3a or 1	3601 FORDS L	ANE, APT.	717		212			USA			
or death with the land of the	11. Marital Status 1 Never Married 2 M	larried Armed For		13. Was	s Decedent of Hisp es, specify Cuban,	oanic Origin? (Spe Mexican, Puerto R	ecify Yes or No Rican, etc.)		e - Ameri ite, etc.	ican Indian, Black,	
ral", or	3 Widowed 4 X Di	1 Yes vorced if Yes, Give Year or Dates:	2 X No	1	Yes 2 No	specify:		Specify	WF	HITE	
hours a	15. Decedent's Education (Spe	ecify only highest grade				on (Give kind of wo DO NOT use retire		16b. Kind of E	usiness/l	Industry	
5-0036 ed within 72 hour bygiene. state then "tate then ble Medical Exar Completed	Elementary/Secondary (0-12)	College (1~	4 or 5+)	SALE	S			RETA	TT.		
	17. Father's Name (First, Middle			DILLI		8.Mother's Name (First, Middle, i				
2121 did be fi Mental J narked event,	HENRY 19a. Informant's Name/Relations	shin (Tyne Print)	NAIDITCH		Address (Street	LEONA and Number or Ru	real Daysto Num	mbor City or To		DELMAN Zin Code)	
MD 21 id 2 should ulth and Me m 27 is ma aumatic ev	LEONA ROSENBI							-		MD 21215	
ore, MC s 1 and 2 s of Health an if item 27	20a. Method of Disposition 1 X Burial 2 Cremation		20b. Place		tion (Name of cem		Date	20c. Location			
Baltimore, cernit. Pages las Department of Hee Important: If ite Injury or other ir	4 Donation 5 Other S	pecify:			OH CEMET		29/2011	l BALT	'IMOF	RE, MD	
Baltimore, ML permit. Pages 1 and 2 s Department of Health at Important: It item 27 injury or other traums	21. Signature of Europal Service	Lice 10 V			ame and Address	201	LEVIN	NSON & I	ROS.	, INC.	
Physician	23a. Part I. Enter the disease, or failure. List only one cause		ised the death. Do			ERSTOWN I				Approximate Interval	
/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	a. Atherosclero		ular Dise	ease					Between Onset and Death	
	Sequentially list conditions,	Due to (or as a c									
ted Insit	if any, leading to immediate rouse. Friter Underlying Course (Disease or injury that initiated	Due to (or as a c	onsequence of):								
to, e be executed ysician and burial - transit	events resulting in death) Last	Due to (or as a c	onsequence of):								
O, e be execut ysician and burial - tra	UNPENDED	AMENDED	tcome of pregnanc								
ox 6876(eath certificate attending phy. for use as the brasician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	су	23d. Date of Month	_	ay Year						
). Box 68760, the death certificate be oy the attending physiciched for use as the buriched Thysician/Med		1 Yes 2 No 9 Unknown Pregnant at time of death 5 Other (Specify)									
o. B at the d d by the stached	Part II. Other significant condit			ing in the ur	iderlying cause giv	ven in Part I.	23e. Did to	bacco use cont	ribute to 1	the cause of death?	
Division of Vital Records, P.O. tal or streading Physician: The law requires that the safer death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detact effication: To Be Completed by P	Diabetes Mellitus					_	1 Yes			ably 4 🗹 Unknown	
Records, The law require ficate has been signage 2 should be							24a. Was autop	sy		topsy findings available ompletion of cause of	
tal Rection: The certificate ector, page	25. Was case referred to medica				00 Bl	-f.D#- (O)	1Yes		Ye	s 2 No	
f Vital Physician or this cert ral directo	examiner? 1 ✓ Yes 2 No	Hospital:	patient 2 ER/	Outpatient		of Death (Check on Other Nursing		Residence 6	✓ Other:	Scene	
ding Ph	27. Manner of Death	28a. Date of (Month, D	Injury 28b ay,Year)	. Time of In	ury 28c. Injury	at Work? 2		now injury occur			
Sior Attend r death ector: by the	- Felic	stigation	of Injury. At home	form street		es 2 No	06 1	Name of the second		-1B - 1 - 1 - 0"	
Division o Division o Hospital or Attending 24 hours after death. Funeral Director: Aftered filled in by the funeral Certification:		d not be (Specify)	of Injury - At home,	iaini, sireet	, ractory, onice bu	ildirig, etc.	or Town, S		er or Rur	al Route Number, City	
Ho Fu		nysician: To the best of miner: On the basis of and manner state	examination and/or								
A Second	29b. Signature and title of certifie				29c. License			29d. Date sign		th, Day, Year)	
10	myh	U. V.			O.C.M	I.E.		July 27, 20	/11		
\		nt Medical Exami	ner 900 W.		Street, Baltir	more, MD 2122	23				
State Registrar	31. Date filed (Month, Day, Year)	32. Regi	strar's Signature	arke	,						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #19a Per FH G918 8/22/2011 JH
State of Maryland / Department of Health and Mental Hygiene For State Registrar 24389 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 July Pey 9:15 Audrey Elizabeth Pennington Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Worcester Berlin 10210 Three Penny Lane 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 1 □ M 2 🛛 F Months Days Hours March, Day Year) 1921 Mary land Yrs. Director 215-16-8019 90 Usual Residence of Decedent or 28a-f show 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** MD Berlin Worcester 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21811 USA 10210 Three Penny Lane 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: white Specify: Completed 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) postal clerk federal government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Katherine Eliza Birch Jacob Washington Esham 19a. Informant's Name/Relationship (Type, Print)
Richard
Pennington 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Son 704 E. Chestnut St; Delmar, Maryland 21875 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, 4X Donation 5 Tother (Specify) 22. Name and Address of Facility State Anatomy Board 21. Signature of Funeral Ser 655 W. Baltimore St; Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Immediate ------e (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ In the past 12 months?

1 Yes 2 No 4 ☐ Pregnant at time of death 9 ☐ Unknown Month Day Year signed by the a d be detached f 1 Yes 2
9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown 1 Tes Completed been si should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy After this certificate funeral director, pag 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 1 Tyes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Leath Certificate: 28b. Time of 28c. Injury at 5 Pending Natural work? 1 ☐ Yes 2 ☐ No Investigation Accident within 24 hours after death

To the Funeral Director, of completed filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the F 3 Certifying Nurse Practioner: To the best of my proyledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one

State Registrar

9b. Signature and title of certif

30. Name and address of person who completed cause of death (Item

29d, Date signed (Month, Dav. Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend Item#1 per phy, g918 8-1-11 sm State of Maryland Department of Health and Mental Hygiene For State Registrar 24390 Reg. N.2 [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JULY 20ear 7:15 AM AnnaPolitakis Anna Politakis 之^a4 Medical 4b. City, Town, or Location of Death Baltimore 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death Keswick Multi-Care Center 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min 1 □ M 2 🗓 F Months Greece 213-62-0073 95 Yrs. **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County aţ 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director notified Baltimore City 1 Yes 2 No MD 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? the Medical Examiner must be Funeral USA items 23a 21224 827 Ponca Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. 'natural", or 1 Never Married 2 Married by ☐ Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: Completed 3 XWidowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ampring or other traumatic event, the Meaonce. Elementary/Seconday (0-12) College (1-4 or 5+) Own HOme <u>Homemaker</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Majden Surname) 2 Irene Xenou Ioannis Patras 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2600 Hudson Street, Baltimore, MD 21224 Nick Politakis - Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 7-27-11 Baltimore, MD 21. Signature of Funeral Service Licen 22. Name and Address of Facility Bradley-Ashton Funeral Home <u>2134 Willow Spring Road,</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph sician/ Intra abdominal adeno car cinema Vietastatic disease or condition Medical resulting in death) Due to (or as a consequence of) primary enknown Examiner 3 months Sequentially liet don ditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 the for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year should be detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? certificate 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ၉ 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred After 1 Natural 5 Pending 1 Yes 2 No within 24 hours after death To the Funeral Director: A 2 Accident
3 Suicide Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) Medical 1 🖳 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M. Tabelle V lac D1365 July 25, 7011

DHMH 17 Rev 7/2009

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
17 IS ABELLE 17 PC PREGOR, 700 W. 40 th STREET, BALTIMORE, M. 21211

Registrar's Signature

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last 2. Date of Death 3. Time of Death 105 Physician/ Medical INMA 4c. County of Death 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner SINAL OSPITAL HIMORE Birthplace (State or Foreign Country) Social Security Number 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea . Age (In yrs, last birthday) **Funeral** 1 M 2 X F Months Min. 86 MANJAND Director 20-108 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits ms 23a or 28a-f sho must be notified at 10c. City. Town or Location Director SSEX 1 Yes 2 No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 2315 21221 U.5-A items (13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Was Decedent Ever in U.S. 11. Marital Status the Medical Examiner Armed Forces? Black, White, etc. 5 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify If Yes, Give Year or Dates White "natural", 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NQT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha ESTALLIAN WNCR Be 17 Father's Name (First Middle Last) 18 Mother's Name (First Middle Maiden Surname permit. Page 1 and 2 should be: Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ew once. Mc DONOUS 2 coneth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip CARDINA 55 20a. Method of Disposition 20b. Place of Disposition (Name of crematory or other place 1 Burial 2 Cremation 3 Removal from State cemetery. 4 Donation 5 A Other (Specify) En tone nplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest one cause on each line. 23a. Part 1. Enter the disc shock, or heart for Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death Due to (or as a consequence of): Examiner O VONAMU C Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis P.O. Box 68760 use as IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 m been signed by the atte should be detached for Day 5 Other (specify) Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ş Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an page 2 s autopsy Yes completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) é 1 Tes 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) Certificate: 27 Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred iniury Natural 5 \square Pending Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and 29d. Date signed (Month, Day, Year) 4090 23a) (Type, Print) FOWE

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State Registrar

Please Type or Print in Black hadelible lik. Ensure All Copies Are Legible. 24392 State of Maryland / Department of Health and Mental Hygiene [] 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 2011 12:50 Anna Frances Radebaugh Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Baltimore Gilchrist Hospice Towson If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 218-14-6036 Nov 18, Days Hours Min Maryland Director 88 Usual Residence of Deceden 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Director Towson Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be 21286 Funeral 119 Linden Terrace USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ğ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: white Completed 3 X Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) should be filed within 72 h and Mental Hygiene. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) self employed florist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ John George Buschman Josephine Ertel other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 si nt of Health a If item 27 i Joseph Radebaugh - son 119 Linden Terrace; Towson, Maryland 21286 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or or 1 🔲 Burial 2 🗌 Cremation 3 🗍 Removal from State 4 Donation 5 Other (Specify) 21. Sig fature Funeral Service icense 22. Name and Address of Facility State Anatomy Board £55 W. Baltimore St; Baltimore, MD 21201 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) Is chemic week Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) and I-transit or Attending Physician: The law requires that the death certificate be executed cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of) physician a the burial-Physician/Medical P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death the 1 ☐ Yes ∠ ■ 9 ☐ Unknown Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Homal Florellation Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? this certificate 2 No Yes 2 N 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Tes 2 40 ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer. 1 Natural 5 Pending work M 1 Yes 2 No Accident Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Hospital Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

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State Registrar

29b. Signature and title of certifier

36. Name and address of person who completed

cause of death (Item 23a) (Type, Print)

Registrar's Signatu

00070635

Charles St Sylve 4105

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? 24393 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Robinson 15380 M Bryant 0. Jr. Medical 4a. Facility Name (if not institution, give street and number) . County of Death \mathbf{PG} 4b. City, Town, or Location of Death **Examiner** Capitol Heights 1125 Carrington Ave Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) **Funeral** Days 1 🗶 M 2 🗆 F Year) 22 Yrs **Director** 577-17-9329 18. 1988 Wash NOV. Usual Residence of Decedent 28a-f show 귫 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director Examiner must be notified Capitol Heights MD PG 1 X Yes 2 ☐ No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? 20743 USA items 23a Funeral 1125 Carrington Ave. Was Deceue... Armed Forces? Ves 2 **X** No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc "natural", or by 1 X Never Married 2 Married Maryland 21215-0036 within 72 hours after Specify: Black If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify. 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working al Hygiene. I other than " life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Student Private Be permit. Page 1 and 2 should be filed.
Department of Health and Mental Homportant: If item 27 is maringury or other. filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Broadhurst Bryant O. Robinson Sr. Avis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 1125 Carrington Ave. Capitol Heights, MD 20743 Bryant O. Robinson Sr./Father 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 XX remation 3 Removal from State 07-30-2011 Metropolitan Crem. Alexandria, VA 4 Donation 5 Other (Specify) Signature of Funeral Service License 22. Name and Address of Facility Ronald Taylor II FH Kovald De 10583 Middleport Ln. White Plains, MD 20695 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ EN OSC disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events burial-trar Due to (or as a consequence of): resulting in death) Last physician the burial Physician/Medical Division of Vital Records, P.O. Box 68760 as attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Lectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? signed by the atte I be detached for Month Year Pregnant at time of death 2 No Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? certificate Yes completed filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: မ 1-Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 / Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) . Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nume Practioner: To the best of my knowled 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type,

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Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		For	Pleas	e Type or Pri		d / Depa	artment of I	Health and				e. 24394	
		State Registrar 1. Decedent's Name	e /Firet Middle I	act)		Cer	tificate of I	Death	2. Date of De	Reg. No		3. Time of Death	
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Medic Examin				ve street and number)		Sie		or Location of Deatl			. County of De		
-		5. Social Security No		Sex 7. Age	In vrs la	st birthday)	If Under 1 Year	If Under 24 Hrs	8. Date of Bi	rth	9.6	Birthplace (State or Foreign	
Funeral Director		INFANT Usual Residence of		1 □ M 2 🗓 F		Yrs.	Months Days	Hours 46	July 2	^{ay, Ye} ar) 20	011 M	Country Land	
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the Mar or 28a e notifi	Funeral Director	MD 10e. Street and Nun	mber			- Daltin	10f. Zip Code		10g. Ci	tizen of What			
n with ns 23a nust b	neral		. Washin				21213			USA			
permit. Page 1 and 2 should be ined within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If firem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.				l I	Vas Decedent of H FYes, specify Cub ☐ Yes 2∑ No	14. Race - American Indian, Black, White, etc. Specify: black					
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2 shoul th and 27 is m trauma		19a. Informant's Na		(Type, Print) - mother			_	and Number or Rushington					
of Heal of Heal fitem :		20a. Method of Disp	oosition		20b. Pl	ace of Dispo	sition (Name of natory or other pla		Date Date	Т		or Town, State	
it. Page rtment rtant: I njury o		4 Donation	5 X Other (Spe	Removal from State	,			ess of Facility St	ata Anat	Omi	Roard		
permi Depar Impor any ir		21. Signature of Fun	onald S	Wade, Sixe	ctor	22		Baltimore				D 21201	
Physician/ Medical Examiner		shock, or hear Immediate Cause disease or condition resulting in death)	rt failure. List only (Final on	mp cations that caused one cause on each line a. Pugara	atu	ence of):		ng, such as cardiad		rrest,		Approximate Interval Between Onset and Death	
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	_	resulting in death) I	Last	Due to (or as a	a conseque	ence of):							
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To the with Com		29b. Signature and	title of certifier	lun	•		29c. Licens	se number 4784	77	29d. Da	ate signed (Mo	nth, Day, Year) 2011	
	_	30. Name and addre	n : .	o completed cause of d	eath (Item	23a) (Type, F	rint)	5+ 72	1+:	صار	100 17	71701	
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		-	1 - For State of Mai State Registrar		irtment of F tificate of L	dealth and Men Death		ne 2011	24395	
	Physicia		Decedent's Name (First, Middle, Last)		2. Date of Death Month 2 year 2 year 2.					
-	Medic		Andrew G. Siske Sr. 4a. Facility Name (if not institution, give street and number)		4h City Town of	r Location of Death	my a	4c. County of Death		
	Examin	er		al Conter	4b. Oity, fown, or	Glen Burnie	a	Anne Aru		
	Funeral		Baltimore Washington Medica 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year		ate of Birth	g. Birth	place (State or Foreign	
	Director		213-28-8883	78 Yrs.	Months Days	Hours Min. (A	Month, Day, Yea August 9,	ar) Cou	yland	
	ind show at	'n	Usual Residence of Decedent 10a. State 10b. County 1	10c. City, Town or Loc	eation			- I	10d. Inside City Limits	
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	Maryland Anne Arundel	Pasadena	ı				1 🗌 Yes 2 🔀 No	
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2 9g	fter o ", or i		Armed Forces? 1 Never Married 2 Married 1 Ses 2 No. If Yes, Give	∘1949-	☐ Yes 2 🔀 No		, 610./	Black, White,		
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Six Ke, Maryland	be fill be fil	잍	Julius Siske			Eva Hartma	an			
15 ary	hould and N s ma uma	П	19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street	and Number or Rural Rou	te Number, Cit	y or Town, State, Zip	Code)	
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ore	of He of He fiten	Н	20a. Method of Disposition	20b. Place of Dispos	sition (Name of natory or other place	Date	200	c. Location - City or T	own, State	
<u>Ĕ</u>	Page ment ant: I ury o		1 🛣 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Cedar Hi			1	Baltimore,	MD	
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Division of Vital Records, P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certifin within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use as	Cert	4 Homicide determined 28e. Place of Injury building, etc. (/ - At home, farm, stre (Specify)	et, factory, office		ocation (Street City or Town, St	t and Number or Run tate)	al Route Number,	
	spital hours ineral d fillec	Medical	29a. Certifier 1 Certifying Physician: To the best of m	y knowledge, death o	ccured at the time	, date and place, and due	to the cause(s	s) and manner as stat	ed.	
	he Ho in 24 he Fu ipleter	Med	(Check 2 ☐ Medical Examiner: On the basis of examiner only one) 3 ☐ Certifying Nurse Practioner: To the be							
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11	-1		30. Name and address of person who completed cause of dea	th (Item 23a) Type, Pi	rint) JUI	MOSPILLE	nie. I	1D. 201	61	
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State of Maryland / Department of Health and Mental Hydiene?

			1 = For State Registrar	State of Ma			icate of L		ivientai m	Reg. No		24398		
	Physici	an.	1. Decedent's Name (First, Middle, L	ast)	0				July 2		011 Year	3. Time of Death		
*	/Medic	cal	Mossalee 4a. Facility Name (If not institution, g		Stevenson Ab. City, Town, or Location of Di						County of Death	6:00 a M		
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	/land		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location	on					10d. Inside City Limits		
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	vith th	Dire	10e. Street and Number	D.I		1	Of. Zip Code	0		-	itizen of What Cou	intry?		
	leeth v	Funeral Director	834 N. Woodin	12 Was Decedent 8	ever in U.S.	13. Was	2122		(Specify Yes or N		JSA 14. Race - Amer	ican Indian,		
0000	be filed within 72 hours after deeth with the Maryland Hygiene. d other than "natural", or itams 23a or 28a-f show event, the Madreal Exeminer must be notified at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 1 N If Yes, Give Year or Dates:	lo		s, specify Cubai Yes 2 No	Specify:	(Specify Yes or N erto Rican, etc.)		Black, White Specify: B1a			
0-017	hin 72 ho s. In "natur Medical	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	Education rade completed) College (1-4or 5		(Give kind	s Usual Occupa of work done d NOT use retired,	uring most of w	rorking	16b. r	(ind of Business/I	ndustry		
7	ed will ygiene yer tha t, the	Сош	12	2		ay1or					othing			
2	il be fil ntal H ed oth	Be	17. Father's Name (First, Middle, La: John	^{t)} Woodwa	rd			18. Mother's Na	ame (First, Middl	ə, Maidei	n Sumame)			
<u> </u>	should nd Me mark matic	2	19a. Informant's Name/Relationship			Mailing Ad	ddress (Street a			ber, City	or Town, State, Zi	ip Code)		
, M	and 2 valith a n 27 is er trat		John Stevenson	(Husband) 834	N.	Wooding	ton Rd.	, Baltin	ore,	MD 2122	29		
Dalilliore	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Department if tien 27 is marked other than "naturel", or Itams 23a or 28a-f show any injury or other traumatic event, the Madical Examiner must be notified at once.		20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 14 ☐ Donation 5 ☐ Other (Spec		20b. Place of cornetery Loudon	r, cremato	ry or other place	ry 7/2	Date 9/11	0.5	imore, M			
סשור	permit. Departr Importe any inju		21. Signature of Funeral Service 1	HSee							uneral H MD 2122			
			23a Part Enter the disease, or co	mplications that caused y one cause on each lin	the death. Do no	ot enter th	e mode of dying	, such as cardi	ac or respiratory	arrest,		Approximate Interval Between Onset and Death		
	sician		Immediate Cause (Final disease or condition resulting in death)	_ a	Den	nent	ia .					Y was		
<i>5</i> 1.	/Medical Examiner			Due to (or as	Due to (or as a consequence of):									
	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a	b. Due to (or as a consequence of):									
6	ecuted and -transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C	a consequence of	۵۱.								
D'no roo	icate be executed physicien and s the burial-transit	alE		200 10 (01 23 1	2 00/138448/108 0	*/-								
000	tificate ig phy: as the	ledical		d										
200	ires that the death certif signed by the attending d be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 4 Pregnant at time of death 5 Other (specify)								23d. Date of delin	d. Date of delivery Month Day Year		
	to the c by the tached	hysi	1 Yes 2 No 9 Unknown	9□ Unknown										
, co	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	þ	Part II, Other significant conditions contributing to death out not resulting in the underlying cause given in Part I.									bute to the cause of death? 3 Probably 4 Unknown		
ט ט	e law requ has been je 2 shouk	Completed							24a. Wa	opsy	prior to c	Were autopsy findings available prior to completion of cause of		
ב ה	: The cate h , page	Con							per 1 Tes	formed? 2 ☐ 1√	death?	2 🗆 No		
	sicien: Th certificate irector, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	nt 2 ER/Out		Othe	er.	eath (Check only		6 □Other (Spec	26.1		
5	ig Phys ter this neral dii	-	27. Manner of Death	28a. Date of Injur (Month, Da)			28c. Injury Work	4 Nursing	28d. Describe			iny)		
5	eath. or: Af the fur	catio	1 Natural 5 Pending 2 Accident investigat 3 Suicide 6 Could not	on he			M 101	res 2 □No						
	s after d el Direct ed in by	Certification:	4 Homicide determine		iry - At home, fari :. (Specify)	m, street,	factory, office		28f. Location City or To	(Street a own, Stat	nd Number or Ru 'e)	ral Route Number,		
	o the Hospital or Attending Physicien: The la within 24 Hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	edical	29a. Certifier 1 Certifying I (Check only one) 2 Medical Ex	Physicien: To the best of eminer: On the basis of and manner sta	examination and	death occ	curred at the tim gation, in my op	e, date and pla- inion, death oc	ce, and due to the curred at the time	e cause(s	s) and manner as nd place, and due	stated. to the cause(s)		
	withii To th	Σ	29b. Signature and title of certifier				29c. License	number 59(69			ate signed (Month			
	7		1 perents	um n			1	- 1169			7.28.4			
	5		30. Name and address of person wh	completed cause of de		Print	Band	En Co	4 3	a litra	er mo	TILLY		
W.	Sta		31. Date tiled (Month, Ony Year)	32. Registra	r's side in		7-	7/0			7 🔻			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	State of Maryland / Department of Heal 1-For State Certificate of Deat		2011 2439
Physician/	1. Decedent's Name (First, Middle,Last)	2. Date of Death Month	3. Time of Death
Medical Examiner		July 29, 201 Town, or Location of Death	4c. County of Death
,	7000 Arundel Mills Circle Hand		Anne Arundel (MM/DD/YYYY) 9. Birthplace (State or
Funeral Director	520-04-0047 1\ M 2□F \ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\	s Days Hours Min. Mar. 1	Co. I Foreign
any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
faryland 28s-f show 1 at once	PA York Hano	ver	1 Yes 2 No
with the Maryland ns 23a or 28a-f sho be notified at once.	10e. Street end Number 10f. Zip 10f. Zi	733 (. Citizen of What Country?
or death with so or items 23 ranust be so Funeral	1 Never Married 2 Married Armed Forces? If Yes, speci	ent of Hispanic Origin? (Specify Yes or No- fy Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
turs after tural", aminer	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual		Specify: VVIII C
y, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 23a-fabutrammite event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	Elementary/Secondary (0-12) College (1-4 or 5+)	rking life. DO NOT use retired)	construction
21215-0036 uld be filed within 72 Mental Hygiene c event, the Medical	17. Father's Name (First, Middle, Last) Gevald Dwight Se	18.Mother's Name (First, Middle, Ma	iden Surname) N Leifold
e, MD 2121 I and 2 should be file alth and Mental item 2: item arice event, reaumatic event, To Be	19a. Informant's Name/Relationship (Type, Print) Gevald D. Sax (0 F1)	(Street and Number or Rural Route Number	er, City or Town, State Zip Code)
2	20a. Method of Disposition 20b. Place of Disposition (Nat Cematory or other place) Removal from State		20c. Location - City or Town, State
Baltimore, permit Pages 1 a Department of He Important: If itie injury or other in	4 Doyletion 5 Other Specify: 21. Signifyire of Funer Service Licensee 22. Name and	Pen Cem Aug 4,2011 Address of Facility SUR	Carlisle St.
	23a, Part I, Enter the disease, or complications that caused the death. Do not enter the mode	F.H. & Crem Hai	10 Ver PAITS 31
Physician ///ledical	failure. List only one cause on each line. Immediate Cause (Final disease a. Multiple Injuries	n dying, such as calculac or respiratory arrest	Between Onset and Death
Examiner	or condition resulting in death) Due to (or as a consequence of):		
iner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause		
ted I Insit Examine	events resulting in death) Last Due to (or as a consequence of): d.		
50, te be executed ysician and burial - transit	UNPENDED AMENDED		
8760, tificate be ng physical as the burnary the burnary the desired the burnary the burna	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death	3 Ectopic pregnancy	23d. Date of delivery Month Day Year
b. Box 6876i the death certificate the attending phy ched for use as the b Physician/M	4 Pregnant at time of death 5 Other (Special Transform) Other (Special Transform) Other (Special Transform)	cify)	
P.O. es that the igned by the detache	Part II. Other significant conditions contributing to death but not resulting in the underlying	,	acco use contribute to the cause of death? 2 • No 3 Probably 4 Unknown
Records, The law requires ficate has been signage 2 should be Completed		24a. Was an autopsy	prior to completion of cause of
Rec : The la ificate h r, page 2	OF Warness of any dispersion like	perform 1 ✓ Yes 2 [26.Place of Death (Check only one)	ed? death? No 1 Yes 2 No
Physician: To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 I	OOA Other Nursing Home 5 Re	
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the safter death. In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacertification: To Be Completed by F	1 Natural 5 Pending FOUND:	28c. Injury at Work? 28d. Describe hor Concrete wall construction v	fell on subject while he was in
Division o spital or Attending nours after death. Increal Director: After filled in by the fune Certification:	2 Accident		eet and Number or Rural Route Number, City te) iills Circle, Hanover, MD
the Hospi hin 24 hou the Funer npletely fil	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in m	e time, date and place, and due to the cause(s) and manner as stated.
To To Court	and manner stated.	i i	29d. Date signed (Month, Day, Year)
	20. Name and address of parent who correlated course of death (flow 22a)	O.C.M.E.	July 30, 2011
0	30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 900 W. Baltimore Stre	et, Baltimore, MD 21223	
State Registrar			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. For State Registrar 24398 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 20^{Year}1 23^{Day} Stephenson Lynn 6:30 A M Charles Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 9731 Clemsonville Road Frederick Union Bridge Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day,) Jun. 10, If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** Year) 943 Country) 1 XM 2 □ F Months Hours 68 **Director** 518-52-0669 Idaho Usual Residence of Decedent show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland notified at Director 28a-f 1 Yes 2 X No Maryland Union Bridge Frederick 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? ms 23a or must be n Funeral 21791 9731 Clemsonville Rd. items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) death 12. Was Decedent Ever in U.S. 14. Race - American Indian. "natural", or iten edical Examiner r Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced White Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) e 1 and 2 should be filed within 72 is of Health and Mental Hygiene.
If item 27 is marked other than "r or other traumatic event, the Medi Elementary/Seconday (0-12) College (1-4 or 5+) 12 trainer & breeder horse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Loren K. Stephenson Virginia Christenson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Union Bridge, MD 21791 Linda Stephenson/wife 9731 Clemsonville Rd. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or oth Date cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/1/2011 Unionville, MD Linganore Cemetery Sign to be of Funeral Service Licens 22. Name and Address of Facility Hartzler Funeral Home a Marine 11802 Liberty Rd. Libertytown, MD 21762 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as car, lac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 10 y disease or condition On Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year the s s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? 24 hours after death. Funeral Director: After this certificate 2 No 1 Yes Yes 2 25. Was case referred to medical director Be 26. Place of Death (Check only one) examiner' Other: 4 \(\sum \) Nursing Home \(\frac{1}{2}\sum \) Residence \(6 \sum \) Other (Specify) 1 Yes 2 No ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) funeral Manner of Death 28b. Time of Certificate: 28c. Injury at Natural 5 \square Pending 1 Yes 2 No Accident the Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Hospital Medical 29a. Certifier Zcertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year, D0031058

Registrar

DHMH 17 Rev 7/2009

State

30. Name and addr

31. Date filed (Month, Day, Year)

AUG 0 1

Ashe

10200 Coppermine Rd

Woodsboro, MD 21798

ss of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Meille 11. 28A M homas 07 22 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hometal houvel PRINCE Reynonal GEORGES hauvel if Under 1 Year If Under 24 Hrs. 5. Social Security Number 7 Age (In vrs. last birthday) 8. Date of Birth 9 Birthplace (State or Foreign **Funeral** 1 M 2 D F Months Hours Min (Month, Day Year) NoV 8, 1962 Maryland Director 48 215-84-1700 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Examiner must be notified at Director 1 ☐ Yes 2X No Prince Georges Laure1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or Funeral 20707 USA 7901 Laurel Lakes Ct #303 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i any injury or other traumatic event, the Medical Examin Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 12 transportation truck driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Garfield Thomas Dorothy Jane Scruggs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7901 Laurel Lakes Ct #303; Laurel, MD 20707 Patricia Thomas - sister 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) 21. Signa ure of Euneral Servi. 22. Name and Address of Facility State Anatomy Board 555 W. Baltimore St; Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cheart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ gasto intrinal disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed MU Due to (or as a consequence of) resulting in death) Last burialattending physician for use as the burial Physician/Medical on hade Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Pregnant at time of death 2 No as been signed by the a 2 should be detached a Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nas page 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Hospital ဥ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred (Month, Day, Year) 5 Pending s after death. ☐ Accident Investigation the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier Carume MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed State AUG 0 1 2011

Registrar

			1 - For State Registrar	State of Ma	arylan		artment of H			R	eg. No.	<u> </u>	24400	
	Physici	an	1. Decedent's Name (First, Middle,							2. Date of Dea Month	th Day	Year	3. Time of Death	
	/Medic		Horace		rer	•				07	18	2011	0130AM	
	Examin	er	4a. Facility Name (If not institution,			4	4b. City, Town, or		of Death		4c. Cou	c. County of Death N/A		
			Genesis ElderCare 5. Social Security Number			iter last birthday)	Baltimore If Under 1 Year	If Under	24 Hrs.	8. Date of Birth	\		place (State or Foreign	
	Funeral Director		212-60-7353	100 M 2□F	58	Yrs.	Months Days	Hours	Min	(Month, Day March 14,	Year)	Cou	Maryland	
			Usual Residence of Decedent										10.1.1	
	trylan show	_	10a. State 10b. County	27/2		y, Town or Lo							10d. Inside City Limits 1 ☑ Yes 2 ☐ No	
	Be-1 s	cto		N/A	Ba.l	timore					Olderen	-414/5		
	with ti	Dir	10e. Street and Number 430 East 22nd St				10f, Zip Code	212	10		rog. Citizen	of What Cou USA	ntry?	
	eath ns 23	Funeral Director	11. Marital Status	12. Was Decedent	Ever in U.	.S. 13.	Was Decedent of Hi	212' spanic Ori		ecify Yes or No-	14. i	Race - Ameri	can Indian,	
0	r iter	Fun	1 Never Married 2 Marrie	Armed Forces?		į	Was Decedent of Hi If Yes, specify Cubar			Rican, etc.)		Black, White,		
Š	ours a	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2 1 No	Specify:			Spe	ecity: Bla	.ck	
215-0036	72 h	etec	15. Decedent's (Specify only highest			16a. Dece	dent's Usual Occupa kind of work done of DO NOT use retired,	ation luring mos	t of worki	ng	16b. Kind o	of Business/Ir	ndustry	
2	within 72 hours after death with the Maryland ene. Ithen "netural", or items 23a or 28e-f show he Medical Evaniner must be notified at	Completed	Elementary/Secondary (0-12)	College (1-4or 5	5+)		Improveme				Se	lf Emp	loved	
N	filed w Hygier other ti		17. Father's Name (First, Middle, L.	ast)						(First, Middle,				
an	d ta b	To Be	Horace Tanner, S	Sr.				Eva I	E. Ow	vens				
	2 shou and M is mar eumat	-	19a. Informant's Name/Relationshi	p (Type, Print)			ng Address (Street a							
	and 2 salth a n 27 is		Linda Tanner - V	Vife			Madison	Avenu						
ore	of He of He or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 ☐Removal from State	C	emetery, crei	sition (Name of matory or other place	_		Date		on - City or T		
Ē	Pages tment of tent: If it		'4 ☐ Donation 5 ☐ Other (Spe	ecify)	Ki		orial Par			9/2011	Wood	lawn,	Maryland	
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Importent: If Item 27 Is marke any injury or other treumatic once.		21. Signature of Funeral Service Li	censee			2. Name and Addres		CLIC	tman-Ha				
			23a. Part1. Enter the disease, or o	complications that caused	the deat		240 Reist					e, MD.	Approximate	
	Physician		shock, or heart failure. List o Immediate Cause (Final	•		. /	10.0-1		-	0			Interval Between Onset and Death	
	/Medical		disease or condition resulting in death)	Due to (or as	a conseq	uence of):	upato e	-1141	ar I	UVCC	10m	a		
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	p #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a conseq	uence of):								
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687	death certificate be executed e attending physician and id for use as the burial-transit	_	3	- d 119 /			LOVO							
Вох	eath certitica attending ph tor use as th	M/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			⊒Ectopic pregnancy				23d.	Date of deliv		
		Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at			Other (specify)					Month	Day Year	
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-	n: T		25. Was case referred to medical	in hy	100	ree	les.	26 Place	e of Deatl	1 ☐ Yes h (Check only o	No No	1 🗆 Yes	2 No	
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to c	ding Phy h. After thi funeral		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	iry iy Year)	28b. Time o	f 28c. Injury Work	at		28d. Describe h	ow injury o	ccurred		
<u>0</u>	eath. or: Al	catic	2 ☐ Accident investiga	ation				Yes 2□						
Division	I or Attendi after death. Director: A I in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Hornicide determin		jury - At he ic. <i>(Specif</i>	ome, farm, st b)	reet, factory, office			28f. Location (5 City or Tox		umber or Ru	ral Route Number,	
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune		29a. Certifier 12 Certifying	Physician: To the best	of my kno	wledge, deat	h occurred at the tim	ne, date ar	nd place,	and due to the	cause(s) and	d manner as	stated.	
	ne Hoor 24 h	Medical	(Check only 2 Medical E	xaminer: On the basis o and manner st		ition and/or in	vestigation, in my or	oinion, dea	ath occurr	red at the time,	date and pla	ace, and due	to the cause(s)	
	To the To the Complet	Ž	29b. Signature and title of certifier	P 8			P 29c. License					igned (Month		
•			Marsin	R. Souls			Ko	876	28		+/	1191.	2011	
			30. Name and address of person w			n 23a) (Type,	8711 N	Eus	fer	St.	MA	7 (7		
	Sta	te	MARCIA K	32. Registr		ature	<i>,</i> _	all	en	ne	1-11)	2120		
	Registr		AUG 0 1 201	Denova D.	160	well								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 24401 Reg. No. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 9:15 AM Physician/ Tul William Larry Taylor Medical 4a. Facility Name (if not institution, give street and number) or Location of Death 4c. County of Death **Examiner** N/A 9. Birthplace (State or Foreign Country) Mary.land Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 M M 2 - F Months Feb. Bay, Yes 40 Yrs 219-36-1458 **Director** Usual Residence of Decedent and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 X No Catonsville MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Funeral 21228 USA 801 Winters Lane Apt. 229 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marijal Status Armed Forces? 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: Black Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Maintenance Movie Theatre 9th Grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Elizabeth Davis Arthur Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 Mercury Court Parkville, MD. 21234 Walter E. Taylor - Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 7/28/2011 Baltimore, Maryland Green Mount Cemetery : 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Signature Juneral Service License Chatman-Harris Funeral Home 5240 Reisterstown Road Baltimore, MD. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ck, or hear failure. List only one cause on each line. Approximate Interval Between
Onset and Death shock, or heart ailu Immediate Cause (Final disease or condition Arrest RESPONATIONS Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Intarction Hyo aerdigl Esquentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) attending physician and for use as the bunal-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Yea Other (specify) Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Inknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 25. Was case referred to medical examiner? the funeral director, 26. Place of Death (Check only one) Be Other: ၉ 1 🗌 Yes 2 X No 1 Inpatient 2 Inpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural 2 Accident injury 5 Pending Investigation after death Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State) 24 hours a Funeral L Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my opinion, death occurred at the time, date and place, and due to the cause 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 75029 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BACTIMONE, MANYCALD State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 2011 Physician/ THOMPSON JUEL 8:00 A JULY 24 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CHARLES WALDORF 10630 SHOOTING STAR LANE Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9, Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 M 2 XF Months Days Hours Min. AUGUST TEXAS 1924 Director 86 447-22-5788 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d, Inside City Limits be notified at Director 28a-f 1x Yes 2 □ No MD WALDORF CHARLES ō 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ns 23a c must b Funeral USA 20603 10630 SHOOTING STAR LANE Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by ☐ Yes 2 X No Baltimore, Maryland 21215-0036 BLACK 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) DOMESTIC HOUSEWIFE 12TH Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental ဂ္ HARKINS MATTIE WILL. ACREY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 8 10630 SHOOTING STAR LANE WALDORF, MARYLAND 20603 Health a MERILYN Y. ROBINSON/DGT 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1:
Department of I
Important: If it
any injury or of ₽ 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) NATIONAL CEMETREY 8/6/2011 LAUREL, MARYLAND J. B. JENKINS FUNERAL HOME, INC. 22. Name and Address of Facility Signature of Fanerah Service License 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, er the 23a, Part 1 shock ure. List only one cause on each line. Interval Between Onset and Death Immediate buse (F e mentia Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) heart disease Examiner Sequentially list conditions, Examiner thany, leading to in medicause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last the burial-trans Due to (or as a consequence of): Physician/Medical certificate be Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birth 2
Pregnant at time of death in the past 12 months?
1 ☐ Yes 2 XNo Month Day Year ate has been signed by the page 2 should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2XI No Yes 2 X No To the Hospital or Attending Physiciam: within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director, I 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 🛣No မှ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 X Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 4 Homicide City or Town, State) 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 JULY 26, 2011 D45737 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JAYANTHAN M.D. 3328 OLD WASHINGTON ROAD WALDORT, MARYLAND 20602 NIRMALADEVI

State Registrar

State Registrar

DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68760,

4940

β2 Registrar's Signature

21224

4940 Eastern Avenue, Baltimore, MD, 21224

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Kornbara

31. Date filed (Month, Day, Year)

AUG 0 1 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Hoalth and Mental Hydiene

Discontates		State Registrar 1. Decedent's Name (First, Midd	lle, Last)			rtificate of	Doui!	2. Date of De			3. Time of Death
Physiciar /Medica		Martin Luth	er White Jr.					July	7 P8	3 20°1°1	10:10 PM
Examine		4a. Facility Name (If not institution 734 W. Wash	in, give street and number ${ t ington}\ { t St}\ \#1$	•		4b. City, Town, c	r Location of Deat S town	th	40	. County of Death Washing	
Funeral Director		5. Social Security Number 215-64-0702	6. Sex 7. A 1 M 2 □ F	ge (In yrs. last i	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		rth a <i>y,</i> Year 195	9. Birth	place (State or Foreign ntsy) Virginia
land Dw	-	Usual Residence of Decedent 10a. State 10b. County	,	10c. City, To	wn or Lo	cation				1	I 0d. Inside City Limits
a-f sh	cto	MD Was	hington	Hag	erst	own					1 □ Yes 2 No
3a or 28	al Director	10e. Street and Number 734 W. Washi	ngton St. #	1		10f. Zip Code 2174	.0			tizen of What Coul	ntry?
irs a	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☒ Mar 3 ☐ Widowed 4 ☐ Divorced	12. Was Deceden Armed Forces 1 Yes 2	t Ever in U.S. ? KNo	1	Nas Decedent of H fYes, specify Cub		Specify Yes or Note Rican, etc.)	0-	14. Race - Americ Black, White, Specify: White	etc.
within 72 hours are giene. r than "natural", or the Medical Exami	Completed	(Specify only highe	nt's Education est grade completed)	16	Sa. Deced	dent's Usual Occup kind of work done DO NOT use retire	nation during most of wo	orking	16b. K	(ind of Business/In	dustry
Hygiene.	E O	Elementary/Secondary (0-12)	College (1-4or	5+)		v truck d			tow	trucking	industry
d oth	lo Be	17. Father's Name (First, Middle, Martin Luther	<i>'</i>					me (First, Middle Jane Bea		Surname)	
th ar	1	19a. Informant's Name/Relations Gina White -		19	9b. Mailir 11	g Address <i>(Street</i> W. Ba lti	and Number or R more St	Apt 627	er, City Ha	or Town, State, Zij gerstown	, MD 21740
if iter		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☒ Donation 5 ☐ Other (5	3 ☐ Removal from State	20b. Place ceme	of Dispo tery, cren	sition (Name of natory or other place	ce)	Date	20c. L	ocation - City or To	own, State
Departmen Important: any injury o		21. Sig laters of Funeral Service Roman d	Licenses D	rector	22	. Name and Addres			-	Board ore, MD 2	21201
nysician	1	23a. Part 1. Enter the disease, o shock, or heart failure. List Immediate are (Final disease or condition	only one cause on each	ed the death. D							Approximate Interval Between Onset and Death
/Medical xaminer		resulting in death)	Due to (or as	s a lonse meno	e of): My's	Hear e due Very	to /in	er dr	Tho.	515	
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the bur	ŭ	resulting in death) Last	Due to (or a	s a consequen	_	- 1					
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in signed by tall be detach	<u>``</u>	Part II. Other significant conditi						23e. Did			he cause of death?
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ertifical ector, pi	D	25. Was case referred medica					26. Place of De	1 ☐ Yes ath (Check only	2 (1) (1)	1 □Yes	2 LUN0
this ce		examiner? 1 Yes 2 No	Hospital: 1 🔲 Inpat	ient 2 ☐ ER/0	Outpatien	t 3 □ DOA Oth	er: 4 🗆 Nursing I	Home 5 Res	idence	6 ☐ Other (Speci	fy)
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within 24 hours after death. To the Funeral Director: A completely filled in by the funeral Director of the funeral Partificati		29a. Certifler 1 ertifying (Check only one)	ng Physician: To the bes Examiner: On the basis and manner s	of examination	ge, death and/or in	occurred at the ti restigation, in my	me, date and plac opinion, death occ	e, and due to the urred at the time	e cause(s , date an	s) and manner as a d place, and due t	stated. o the cause(s)
To the comp		29b. Signature and title of certifie	,,16	Aju	1.D.	29c. Licens	04113	1	J	ite signed (Month,	1,2011
		30. Name and address of person	who completed cause of	death (item 23a	(Type, I	arel Op	al Coury	+ chance	gers.	town, n	ND 21740
State	_	31. Date filed (Month, Day, Year)	33. Regist	rar's Signature							

Registrar DHMH 17 Rev 1/2001

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edical Examin		Madeline McCoy Webster						Month July 25,	Day	Year	1830 hrs
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Funeral		5. Social Security Number 6. Sex 7. Age	e (In yrs. la	st birthday)		der 1 Yea			Birth(MN		irthplace (State or
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AD 2 sh	1	Kim McCoy - Daughter						Baltimore			
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Page Page ment c		4 Donation 5 Other Specify:		tern St				8/5/2011	Cat	tonsvill	e, Maryland
Baltimore, permit. Pages 1 ar Department of Her Important: If ite injury or other tr		21. Signature of Funeral Service Licensee		- 1			of Facility	Chatman-	-Harı	ris Fune	ral Home
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/Medical		failure. List only one cause on each line. Immediate Cause (Final disease a. Hypertensive At	heroscle	erotic Card	iovascı	ular Dis	sease Con	onlicated by H	lvperth	ermia	Between Onset and Death
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Division of Vital Records, To the Hospital or Attending Physician: The law requir Within 24 hours after death. To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should the	Certification:	3 Suicide 6 Could not be determined (Specific) Day		me, farm, stre	et, factory	y, office b	ouilding, etc.	or Town	State)		Rural Route Number, City
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		man, mo				O.C.	M.E.		Jul	y 26, 2011	
	İ	30. Name and address of person who completed cause of d			ro Ct	o4 D 1	ima and Add	24222			
		Ling Li, MD Assistant Medical Examiner 31 Date filed (Month Day Year) 32 Registrar			re Stre	et, Ball	imore, ML	J Z1ZZ3			
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ORIGINAL

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death ecedent's Name (First, Middle, Last) 2. Date of Death Physician/ 15A M Dencer Medical Eacility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner timore limonium 9. Birthplace (State or Foreign Country) **Funeral** Age (In yrs. last birthday) 8. Date of Birth Days 1 M M 2 🗆 F Min (Month, Day Director 10a. State filed within 72 hours after death with the Maryland 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at Town or Location Director 1 Yes 2 No timore 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21230 Was Depedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban Mexican, Puerto Rican, etc.) 14. Race - American Indian, Completed by 1 Never Married 2 Yes Yes, Give 2 🗌 No Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify "natural" 3 Widowed 4 Divorced Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname ၉ Page 1 and 2 should be or other traumatic ind 2 if Health au in 27 is m 19b. Mailing Address (Stree Minore, MU21207 Baltimore, 20a. Method of Disposition Date permit. Page 1 a
Department of IImportant: If ite
any injury or ot 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) e of Fungral Service Lidense 21. Signat 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ RENAL DISEASE Medical Due to (or as a consequence of): ^{*}Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Physician/Medical Exam Cause (Disease or linjulation initiated events resulting in death) Last been signed by the attending physician and should be detached for use as the burial-tran Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death
Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 No 3 Probably 4 Unknown 1 🗌 Yes Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy death? 2 No 1 ☐ Yes 2 🛣 No 1 Yes Be 25. Was case referred to medica 26. Place of Death (Check only one) Hospital Other 2 🗶 No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 K Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes Certificate: 28d. Describe how injury occurred 1 🕅 Natural injury 5 Pending 2 No Accident Suicide Investigation within 24 hours fer dear To the Funeral Cirector 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature ar 29c. License number ည 29d. Date signed (Month, Day, Year, ess of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

JACKIE JONES,

CRNP

2011

BERNARD WHITE

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend#10e,19bperfn g918 8-1-11 d.o. State of Maryland / Department of Heath and Mental Hygien 2 1 For State Registrar 24407 Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Wilder Shirley Jean Medical 1506 July 20 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Anne Arundel Medical Centery Annapolis Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs, last birthday **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days 1 □ M 2 💢 F Months Min. Hours (Month, Day, Year) 2-29-1937 241-58-1485 73 Director North Carolina Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location notified at Director 10d. Inside City Limits 28a-f MD Calvert North Beach 1 X Yes 2 No with the 10e. Street and Number items 23a or ner must be n ò 10f. Zip Code 10g. Citizen of What Country? Funeral 20714 9314 Sea Oak Ct. Sea Oat Ct USA permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner m. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. Armed Forces?

1 Yes 2 No þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: Specify: Black Completed 3 Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Laurel Elementary/Seconday (0-12) College (1-4 or 5+) Hospital Administrator Beltsville Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Katie Boykins ည Luther Josiah Wilder Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9314 Sea Oak Ct. North Beach, P1D 20714 Patricia Kenan/Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 07-29-2011 Landover, MD Harmony Memorial Cem Signature of Funeral Service Licer 22. Name and Address of FacilitiRonald Taylor II Fin Koovall 10583 Middleport Ln. White Plains, MD 20695 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death - Ph. sician/ Hemother disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin Cause (Disease or linjury that initiated events resulting in death) Last and-tra Due to (or as a consequence of) inding physician ause as the burial-Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE asn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? ò Month Pregnant at time of death Day Year the hed t Yes No Unknown 9 Unknown P.O. signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, should Completed 1 Yes 2 No 3 Probably 4 Onknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s performed After this certificate 1 Yes 2 No Yes 2 N Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' 1 🗌 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 1 | Inpatient 2 | ER/Outpatient 3 | DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A Accident filled in by the Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check within 2 only one Certifying Nurse Practione the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature a

State Registrar

d title of certifier

201

31. Date filed (Month, Day, Year,

AUG O

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar

29d. Date signed (Month, Day, Year)

201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2 013 are Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 5111 Duel Pl. PG Capitol Heights Social Security Number 6. Sex 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F (Month, Day, Year) 05-18-1948 Country) Wash DC Director 578-64-4080 63 Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits MD PG Capitol Heights 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5111 Duel Pl. 20743 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Bace - American Indian. Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Completed by 1 Never Married 2 Married Yes, Give 2 **X** No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: SpecifyBlack 3 X Widowed 4 ☐ Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) National Science Elementary/Seconday (0-12) College (1-4 or 5+) 12 Grant Technician Foundation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown Louise Davis 19a. Informant's Name/Relationship (Type, Print 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1020 Ashley Lakes Dr. #1020 Norcross, GA 30092 RAYMOND T. WASHINGTON/Son Department of Hea Important: If item 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) ō 1 XBurial 2 Cremation 3 Removal from State Waldorf, MD any injury 4 Donation 5 Other (Specify) Heritage Memorial Pk 08-04-2011 21. Signature of Funeral Service License 22. Name and Address of Facility Ronald Taylor II FH Koonda 10583 Middleport Ln. White Plains, MD 20695 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause Immediate Cause (Final Onset and Death **Physician** disease or condition resulting in death) Medical ue to (as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and debached for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Other (specify) Month Day Year 9 Unknown Unknown Pther significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 No 3 Probably 4 Donknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has DIG BO C

Was case referred to medical examiner?

1 □ Yes 2 ☑ No certificate | performed' 1 🗌 Yes 2 🗆 No Be 26. Place of Death (Check only one) Other: မ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 1 Natural injury 5 Pending work? 1 🔲 Yes Accident 2 No Investigation Funeral Director: Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title of certific 30. Name and address of person who completed cause of death (Item 23a) Type, Print) 6128 Landover Road Cheverly Maryland Margaret Akpan 20785

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year

AUG 0 1 2011

32. Registrar's Signature

11-05573

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Bisbee Allen 24409 1- For State Certificate of Death Reg. No. Ragistrar 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day July 26, 2011 Allen Bisbee 0045 hrs Medical Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Harford Churchville Rt. 136 @ Rolling Road 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs 5. Social Security Number **Funeral** oreign Country) Days 624-36-6262 Months Hours 21 03/12/1990 Director 1X M 2 F Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County Churchville MD Harford 1 Yes X No 28a-f sho Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If iten 27 is marked other than "natural", or itens 23a or 28s-f sho
injury or other traumatic event, the Medical Examiner must be notified at once. Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 202 Maxwell Court 21028 USA Funeral 11. Marital Status 14 Race - American Indian, Black, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 Married 1 Yes 2 X No Yes, Give Year or Dates: 3 Widowed 4 Divorced 1 Yes 2 No specify: Š 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 n/a Laborer 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) David Allen Mary Sova å 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ၉ 19a. Informant's Name/Relationship (Type, Print) 202 Maxwell Court, Churchville, MD 21028 Mary E. Sova / Mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition Final Journey Crem. 1 Burial 2 X Cremation 3 Removal from State 7/29/2011 Woodbine, MD 4 Donation 5 Other Specify. 22. Name and Address of Facility 21. Signature of Furreral Service Licensee Dorota Marshall Maryland Cremation Ser PO Box 1413, Baltimore Services ore, MD Leanston 21203 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line /Madical Death a Multiple Blunt Force Injuries Immediate Cause (Final disease or condition resulting in death) Examine Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last pue Physician/Medical UNPENDED AMENDED attending physician or use as the burial -Hospital or Attending Physician: The law requires that the death certificate be Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year Live birth 2 Fetal death past 12 months? Pregnant at time of death 5 1 Yes 2 No 9 Unknown 9 Unknown ned by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was en 24b. Were autopsy findings available certificate has been prior to completion of cause of autopsy page 2 performed? Yes 2 No 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical 8 examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗸 Other: Scene this 1 🗸 Yes 28a. Date of Injury (Month, Day, Year) Jul 26, 2011 28d Describe how injury occurred After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Driver auto tractor trailer collision 0037 hrs 1 Natural 1 Yes 2 ✔ No Director: / Pending 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc within 24 hours after To the Funeral Dire 3 Suicide 6 Could not be or Town, State) Rt. 136 @ Rolling Road, Churchville, MD determined (Specify) Road Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier July 27, 2011 O.C.M.E. 30. Name and eddress of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Dale (10G MO" 2 2017 32. Registra s Signature State

DHMH 17 Rev 1/2001

Registra

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 8:05 P M J. Augustinovicz 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 310 Amy Drive Abinadan Harford Social Security Number 6. Sex 1 M 2 □ F If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Age (In vrs. last birthday) **Funeral** Days Jan. 12, 1921 222-24-9954 90 Pittsourg, PA Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location Director 1 Yes 2 No Maryland Harford Abingdon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 310 Amy Drive 21009 U.S.A. 12. Was Decedent Ever in U.S. Argued Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 No 1942 -1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: White 1973 3X Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Food Manufacturing Plant Maintenance Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Louise Olbrysh Bolslaw Augustinovicz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Laura Orsini (Daughter) 310 Amy Dr. Abingdon, Maryland 21009 Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date Unk 20c. Location - City or Town, State Arlington National Caletery 4 ☐ Donation 5 ☐ Other (Specify) Arlington, Virginia 21. Signature of personneral Service Licensee Jeffrey Testerman Evans Puneral Chapel & Cremation Services - Bel Air (M01543) 3 Newport Drive, Forest Hill, Maryland 21050 23a. Part 1. There the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ won disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions. Examine Due to (or as a consequence of). if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Pregnant at time of death 1 Yes 2 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Ubstructive Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 KProbably 4 ☐ Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of 24a, Was an the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2.9 performed? Yes 2 No Dicoderial 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospita! Other: 2 **X**No 1 🗌 Yes ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 who completed cause of death (Item 23a) (Type, Print State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ames A. Allred	State of Maryland / Department of 1-For State Certificate of		ygiene Reg. No. 201	24411						
Physician/ ledical Examiner	1. Decedent's Name (First, Middle, Lest) James Arthur Allred		2. Date of Death Month Day Year July 30, 2011	3. Time of Death 2003 hrs						
	4a. Facility Name (if not institution, give street and number) Sinai Hospital	4b. City, Town, or Location of Death Baltimore		ath						
Funeral Director	$ \begin{array}{cccccccccccccccccccccccccccccccccccc$	If Under 1 Year If Under 24Hrs Months Days Hours Min	T IFore							
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other transmatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 3 Wildowed 4 Divorced 1 Yes, Give Year 1 Decedent's Education (Specify only highest grade completed) 1 Secondary (0-12) 1 College (1-4 or 5+) 1 Decedent's Name (First, Middle, Last) 1 Elementary/Secondary (0-12) 1 Paul Informant's Name/Relationship (Type, Print) 1 Sunday Allred 1 Seminary Secondary 2 Method of Disposition 1 Sunday Address 2 No specify: 3 Whispanic Origin? (Specify Yes or No-lif Yes, Specify: Whispanic Origin?) 1 Welder / Specify: 3 Whispanic Origin? (Specify Yes or No-lif Yes, Specify: Whispanic Origin?) 1 Newport Drive, Forest Hill, Maryland 1 Newport Drive, Forest Hill Newport Drive, Forest Hill, Maryland 1 Newport Drive, Forest Hill Newport									
50,	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last MI UNPENDED AMENDED AMENDED AMENDED AMENDED AMENDED Do not enter the disease, or complications that caused the death. Do not enter the death. Do not enter the death. Do not enter the disease, or complications that caused the death. Do not enter the death line.	nd Alcohol Intox	ication	Approximate Interval Between Onset and Death						
of Vital Records, P.O. Box 6876 ing Physician: The law requires that the death certificate After this certificate has been signed by the attending phyfuneral director, page 2 should be detached for use as the on: To Be Completed by Physician/M	4 Pregnant at time of death 5 Oth 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the uncontributing of the uncontribution to death but not resulting in the uncontribution to death but not resulting in the uncontribution to death but not resulting in the uncontribution to death but not resulting in the uncontribution to death but not resulting in the uncontribution to death but not resulting in the uncontribution to death but not resulting in the uncontribution to death but not resulting in the uncontribution to death but not resulting in the uncontribution to death but not resulting in the uncontribution to death but not resulting in the uncontribution to death but not resulting in the uncontribution to death but not resulting in the uncontribution to death but not resulting in the uncontribution to death but not resulting in the uncontribution to death but not resulting in the uncontribution to death but not resulting in the uncontribution to death but not resulting in the uncontribution to death but not	26.Place of Death (Check of 3 DOA Other 1 Nursing jury 28c. Injury at Work? 1 Yes 2 X No	23e. Did tobacco use contribute to 1 Yes 2 No 3 Pro 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2	Day Year of the cause of death? obably 4 Unknown outopsy findings available completion of cause of yes 2 No						
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	30. Name and address of person who completed cause of death (Item 23a) Jack Titus MD. Deputy Chief Medical Examiner 900 W. B. 31. Date filed (Month, Day, Year) 32. Registrar's Signature	O.C.M.E. altimore Street, Baltimore,	July 31, 2011 MD 21223							

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2			For State Registrar		State o	f Marylar			nt of Heal e of Dea		Mental Hy	giene Reg. 2	11	24412
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200	Examir		4a. Facility Name (if not in				er.	4b. City,	Town, or Loca	tion of Death		4c. Coui	nty of Deat	th Torre
	Funeral Director		5. Social Security Numbe 212-44-58		Sex 1 M 2 F	7. Age (<i>In yrs</i> .	last birthday) Yrs.	If Unde Months		nder 24 Hrs. urs Min.	8. Date of Birt (Month, Day	v, Year)		thplace (State or Foreign untry)
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ision	Attendir er death. ector; Af by the fu	Certificate:	2 Accident	☐ Pending☐ Investigation☐ Could not determined	be 28e. Place o	of Injury - At ho	ome, farm, stre	М	1 Tes	2 □ No			ber or Rui	ral Route Number,
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	the He thin 24 the Fu mplete	Mec	only one 3 C	Aedical Exam	niner: On the basis	of examination	n and/or investi	gation, in	my opinion, dea	th occurred a	t the time, date an	nd place, and o	due to the c	cause(s) and manner stated.
			29b. Signature and title of	or certifier	Lin	th.c	w.	290	D3182			29d. Date sign		
	PXI		30. Name and address of				1 23a) (Type, Pr	,	npruc	TOLIS	SON. MAI	PVI DNI	0 210	204
	Stat Registra	•	RICHARD 31. Date filed (Month, Day AUG 0 2 201	y, Year)		gistrar's Signa			W171 V III	LOWE	25023 Ny - 113891	N I loss E TIMA	ar tamah la	oor 'ee' &

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2 o 11 Physician/ 7404AM <u>Rostislav Adamek</u> νl Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign Social Security Number **Funeral** nth, Pay Hours 1 🗙 M 2 🗆 F Days Min Czech Republic 1934 Director Nov 223-25-2611 Usual Residence of Decedent or 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits be notified at Director 1 Yes 2 X No Montgomery Gaithersburg Maryland 10e. Street and Number 10g. Citizen of What Country? 23a by Funeral permit. Page 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must I United States 20878 307 West Side Drive #201 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced White Completed Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Construction 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Slukova Anna Frantisek Adamek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 307 West Side Dr. #201 Gaithersburg, MD 20878 Erzika S. Adamek / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State Woodbine, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 8/3/2011 Signature of Funeral Servic Loens Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final CArdiac Physician/ arres disease or condition resulting in death) minutes **Medical** Due to (or as a consequence of **Examiner** MyocArdia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last pronar Due to (or as a consequence of Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Pregnant at time of death Yes 2 No 1 Yes 2 g g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Dichetes Mellits type 2. 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown Chronic obstructive Pulmona 24a. Was an 24b. Were autopsy findings available within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 secondleted filled in by the funeral director, page 2 secondleted filled in by the funeral director, page 2 secondleted filled in by the funeral director, page 2 secondleted filled in by the funeral director, page 2 secondleted filled in by the funeral director. prior to completion of cause of death? autopsy performed li sperlipidemic 1 Yes 2 X No 25. Was case referred to medica Be 26. Place of Death (Check only one) Hospital Other: ၉ 1 🗌 Yes 2 No 1 Ninpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 12 Scrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

29b. Signature and the 29d. Date signed (Month, Day, Year) August 1,2011 00063163 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Maryland 20850 Drive Rockville 9901 Medical Center State Registrar

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

(Check

only one

	1	For State Registrar	State of Ma	arylan		artment rtificate				giene Reg. No	/ [2]		241	. 4
Physiciar /Medica		1. Decedent's Name (First, Middle, Last Anthony			Ar	1452	ews	Ki	2. Date of De Month	3) 2		3. Time of 17:0	Death 5 M
Examine		4a. Facility Name (If not institution, give The Johns Hopkii 5. Social Security Number 6. Se	15 HOSP	ital	last birthday)	Bal If Under 1	tim(nder 24 Hrs.	8. Date of Bir (Month, Da	th	. County	9. Birth	place (State ontry)	or Foreign
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12 shou th and M 7 is man traumat	-	19a. Informant's Name/Relationship (T		١				lumber or Rura						
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	the land a or 2 be no		10e. Street and Number		10f. Zip Code	-		10g. Citizen of Wha	
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To the	within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		only one) 3 Ucertifying Nurse Practioner: To the besi 29b. Signature and title of certifier	A #	death occurred at the 29c. License		ce, and due to th	e cause(s) and manne 29d. Date signed (N	
			▶ ENDNU MD Attending H.	Phy Sic	1m DO	071039		-	31. 2011
_			30. Name and address of person who completed cause of death	ı (Item 23a) (Type	Print)		_	1	
			Ethol Weld 440 Grindall 31. Date filed (Month, Day, Year) 32. Registrar's		Himore 1	ND 2/2	30	.	
	Stat Registra	e Ir	31. Date filed (Month, Day, Year) 32. Registrar's 32. AUG 0 2 2011	1. par	Kel				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra 24416 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Ilene W. Brown Physician/ July Day 201^{Yea} 28 6:02A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Clinton 4c. County of Death **Examiner** Southern Maryland Hospital Prince George's If Unde Social Security Number 288-24-8062 . Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 1 □ M 2**XX** Months Days Hours 02/28/1929 82 **Director** OH Usual Residence of Decedent 28a-f show 10a. State 10b. County ral", or items 23a or 28a-f shorexaminer must be notified at 10d. Inside City Limits 10c. City, Town or Location Director Prince George's MD Suitland 1 Yes 2 X No 10f. Zip Code 20746 10e Street and Number 10g. Citizen of What Country? Griffith Drive Funeral 6012 within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🖾 No If Yes, Give 27 is marked other than "natural", or i traumatic event, the Medical Examin þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: White 3 Novel 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Cashier Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First Middle, Maiden Surparpe)
Estelline Hoffman 1 and 2 should be fill of Health and Mental item 27 is marked o Wilson ပ Harry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12037 Palisades Drive, Dunkirk, MD 20754 Quinta Outridge/Daughter injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Final Journey Crem. Woodbine, MD 8/1/201 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Dorota Marshall 22. Name and Address of Facility Maryland Cremation Services PO Box 1413, Baltimore, MD 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final M 1SJIM 001-did Ph sician/ disease or condition resulting in death) Medical ue to (or as a consequence of) **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Examiner Dun to for es a nonsacuenna on Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? ō Month Dav Year Pregnant at time of death No ate has been signed by the a page 2 should be detached t 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 况 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? After this certificate 1 Yes 2 No the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Other: မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? within 24 hours after death.

To the Funeral Director: A Accident Investigation M 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide completed filled in by determined 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29/1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)
AUG 0 2 2011 State Registrar

DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygien) For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 3 c Physician/ Month 3010 752 PM LAWRENCE J. BAYNE Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltown ハれ If Under 1 Year If Under 24 Hrs. 5. Social Security Number Sex 1 M 2 D F 9. Birthplace (State or Foreign 8. Date of Bir 7. Age (In vrs. last birthday) **Funeral** Days Min. Months Yrs **Director** 28/1920 MARYLAND 215-12-9579 90 Usual Residence of Deceden 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f MD BALTIMORE ROSEDALE 1 Yes 2 No 10g. Citizen of What Country? 0 10e. Street and Number 10f. Zip Code ms 23a or must be Funeral 1412 ROSEWICK AVENUE USA "natural", or item ledical Examiner n 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. B 1 Never Married 2 XMarried by 1 ☐ Yes 2 ☐XNo Specify Specify: WHITE Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Seconday (0-12) 12 College (1-4 or 5+) Department of Health and Mental Hygiene Important: If item 27 is marked other the any injury or other traumatic event, the I once. FOREMAN INSTRUMENT TECHNICIAN BETHLEHEM STEEL Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Page 1 and 2 should be ment of Health and Ment WILLIAM JAMES BAYNE ESTELLA SCHNEIDER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DOLORES BAYNE-WIFE 1412 ROSEWICK AVENUE BALTIMORE, MD 21237 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State DRUID RIDGE CEM. 4 Donation 5 Other (Specify) 8/3/2011 BALTIMORE, MARYLAND Signature of Funeral Service Licensee 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME 6415 BELAIR ROAD BALTIMORE, MD 21206 Tan 1. Friter the discase shock, or heart failure. Li Diplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ DINGESTVE disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions Examiner Due to (or as a consequence or). if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as attending IE FEMALE: asn 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No 9 Unknown be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed' death? certificate 2 No Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics 25. Was case referred to medical completed filled in by the funeral director, Be 2 No Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 Tes Certificate: To 1 ■ Inpatient 2 □ ER/Outpatient 3 □ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be 3
Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and tille of 2011 4067 son who completed cause of death (Item 23a) (Type, Print) 30. Name and address of 2401 W. BELVEDERE AVE. BALTIMORE, MD 21215 South u 0 31. Date filed (Month Year State AUG Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes State
Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2011 Physician/ Joseph Vincent Brady 29 1:39 PM July Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death
Baltimore 4b. City. Town, or Location of Death Examiner Towson Gilchrist Hospice 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 ★ M 2 □ F Months 03/28/1922 057-14-6665 89 Yrs. Director Usual Residence of Decedent 28a-f shov 10a. State ms 23a or 28a-f shomust be notified at 10b County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore MD 1 ¥ Yes 2 ☐ No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1000 Fell Street Unit 610 21231 Funeral ral", or items 2 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 White If Yes, Give Year or Dates. Army 1 ☐ Yes 2X No Specify: Specify "natural", Completed 3 Nidowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Education 12 Professor traumatic event, Be 18. Mother's Name (First Middle, Maiden Surname)
Mary Michaelson 17. Father's Name (First, Middle, Last) should be file and Mental I is marked o James Brady ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Fural Route Number, City or Town, State, Zip Code) 1000 Fell St., Unit 610, Baltimore, MD ge 1 and 2 short of Health a Nancy H. Brady / Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place)
Final Journey crem. 20a. Method of Disposition Date 20c. Location - City or Town, State ☐ Burial 2 X Cremation 3 ☐ Removal from State ö Department of Important: If any injury or once. 8/2/2011 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Maryland Cremation Serv
PO Box 4113, Baltimore, Signature of Funeral Service Licensee Dorota Marshall Services Marsharl 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ rnemonic well Co disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of, -transit requires that the death certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last physician a sthe burial-t Physician/Medical Box 68760 attending ph IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 2 No ed by the a detached f 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by stricture. atrial Film 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy performed death? 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 2 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) avinc within 24 hours after death.

To the Funeral Director. After this completed filled in by the funeral dir 28c. Injury at work?
1 Yes 2 No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate To the Hospital or Attending 1 Natural 5 Pending injury Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the est of my mowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1701 NLUS State Registrar

HMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 24419 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July Patsy R. Bonvegna 2011 4:45p Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death . County of Death Baltimore 4886 Bright Leaf Court Baltimore Social Security Number 8. Date of Birth (Month, Day, Year) June 15, 1932 9. Birthplace (State or Foreign Country) MD 6. Sex If Under 1 Year | If Under 24 Hrs. **Funeral** Age (In yrs. last birthday) Days 1 □ M 2 □¥ Min. 212-28-2124 Hours 79 **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director be notified 28a-f Baltimore Baltimore MD 1 Yes 2 No 10f. Zip Code 21237 10e. Street and Number ö 10g. Citizen of What Country? ms 23a o must be Funeral 4886 Bright Leaf Court USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Specify: White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12th College (1-4 or 5+) other traumatic event, the Banker Mercantile Bank Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) h and Mental H မ Robert Briggs Loretta Boswell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2609 GunpowderFarms Road Fallston MD21047 Health tem 27 Michael Mehring/son-in-law 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important: If it any injury or o Oak Lawn Cemetery 8/4/11 1 Burial 2 Cremation 3 Removal from State Baltimore MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Balto. MD 21. Signature of Funeral Service Licenses WD Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Metes faction Cancer disease or condition resulting in death) calon Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): ending physician and use as the burial-transit Exam Lause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death signed by the and be detached for P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? 1 ☐ Yes 2 ☐ No 2 🖳 🕅 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Certificate: To I 1 ☐ Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending wark 1 Yes 2 🗆 No Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD D0058893 August 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar BIRCONE

31. Date filed (Month, De

MID

Eastern

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MD 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 24420 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July Albert Carroll Bowers 30° 2011 1:35 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Stella Maris Hospice Timonium Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Months 216-03-8135 Hours Aug. 29,1918 92 Director Maryland Usual Residence of Decedent shov 10b, County 10c. City, Town or Location 10a. State ortant. If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director Parkville MD Baltimore 1 Yes 2 X No 10e. Street and Number 10g. Citizen of What Country? Funeral 8800 Old Harford Road 21234 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No If Yes, Give ₩₩Т Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married ð Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 3 XWidowed 4 Divorced WWII Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Hendlers Ice Cream Ice Cream Maker 9 Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed.
Department of Health and Mental H
Important: If item 27 is marked ott
any injury or other traumatin aver-18. Mother's Name (First, Middle, Maiden Surname) Carroll Bowers Nettie Bull 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Albert L. Bowers/Son 373 Enfield Road, Joppa, MD 21085 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State August 1 X Burial 2 Cremation 3 Removal from State Gardens of Faith Rosedale, Maryland 4 Donation 5 Other (Specify) Cemetery 2011 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Chapel & Cremation Services 8800 Harford Rd. Parkville, MD 21234 23a. Part 1. Enter he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Onset and Death Ph sician/ ASPIRATION PNEUMONIA Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical ding p IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 1 ☐ Live Birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy Hospital or Attending Physician: The law requires that the death. 24 hours after death. Funeral Director: After this certificate has been signed by the atter in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Year 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) Hospital Other 1 Yes 2 X No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Tother (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred X Natural 5 Pending injury work? 1 Yes 2 No ☐ Acciden☐ Suicide Accident Investigation 6 Could not be To the Hospital or Atte within 24 hours after de To the Funeral Directo completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and ti 29c. License number ed (Month, Day, Year) 2011

Registrar
DHMH 17 Rev 7/2009

State

341

30. Name and ago

JONES, CRNP

AUG 0

2011

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

rson who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

		•	1 - For State Of Maryland Registrar		tificate of D			Reg. No.	2011	24421
	Physicia Medic		1. Decedent's Name (First, Middle, Last) CATHERINE BRISCO	E			2. Date of Dea Month	oth Day	Year 2011	3. Time of Death
	Examin	er	4a. Facility Name (if not institution, give street and number)			Location of Death		4c. (County of Death Howa	_
	Funeral Director		Lorien Nursing Home 5. Social Security Number 6. Sex 1 M 2 X F 85	t birthday) Yrs.			8. Date of Birtl (Month, Day	, Year)	9. Birth	place (State or Foreign
		1	Usual Residence of Decedent	Town or Loc	ation	11	12 10			10d. Inside City Limits
	Marylan 28a-f sh atified a	recto		Balti						1 XYes 2 No
	with the I s 23a or 2 ust be no	Funeral Director	10e. Street and Number 3437 Round Road		10f. Zip Gode 21 2	225		10g. Citiz	ven of What Cou	-
036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.	by	11. Marital Status 1 ↑ Never Married 2 ↑ Married 3 ↑ Widowed 4 ↑ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ↑ Yes 2 ↑ Yes, Give Year or Dates.		/as Decedent of His Yes, specify Cubar ☐ Yes 2 🔀 No	spanic Origin? (Spen, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		4. Race - Ameri Black, White, Specify: B1	
215-0	nin 72 hou ne. han "natu e Medical	Completed	(Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)	(Give ki life. DC	NOT use retired)	ation Juring most of work	ing		nd of Business Ir	Service
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rylan	uld be fi I Menta marked natic ev	To	William Briscoe			Hattie				
, Mai	nd 2 sho ealth and m 27 is r	5	19a. Informant's Name/Relationship (Type, Print) Thomas Briscoe-Brother	10506	Address (Street a	and Number of Burn am Tell	Lane,	Co1	own State Zip Umbla,	^{Co} Md 21044
Baltimore, Maryland 21215-0036	Page 1 al ment of H tant: If itel iury or oth		1 Burial 2 Cremation 3 Removal from State cem	netery, crem	sition (Name of atory or other place nedral	θ)	Date / 2011		cation - City or T	·
Balt	permit. Depart Import any inj	(21. Signatur of Funeral Service Licensee	22. Ma	Name and Addres	ss of Facility H West ash Ave	Pal+i	imor	o. Md	21215
	Physician/	1	23a. Part 1. Enter the disease, or complications that caused the death. In the cause (Final Immediate Cause (Final disease or condition)	Do not enter	the mode of dying	g, such as cardiac o	or respiratory arre	est,		Approximate Interval Between Onset and Death
	Medical Examiner		resulting in death) Due to (or as a consequen-							
K	ted i nsit	Examiner	Sequentially list conditions, if any, feating to immediate cause. Enter Underlying Cause (Disease or linjury	iče ofj.						
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8760	tificate ng phys as the	Medical	IF FEMALE:							
P.O. Box 68	Hospital or Attending Physician: The law requires that the death certifat hours attendenth. 24 hours attendenth. 24 hours attendenth attending properties that been signed by the attending the properties attending the funeral director, page 2 should be detached for use set of filled in by the funeral director, page 2 should be detached for use.	Physician/I	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal of 4 Pregnant at time of dear 9 Unknown	leath 3 🔲	Ectopic pregnancy Other (specify)	у		2:	3d. Date of deliv	very Day Year
ds, P.0	requires that the de been signed by the should be detached	by	Part II. Other significant conditions contributing to death but not resulti	ing in the un	derlying cause give	en in Part I.				the cause of death?
Division of Vital Records,	sician; The law rec certificate has be irector, page 2 shc	Completed					24a. Was a autop perfor 1 Yes	sy med?		opsy findings available ompletion of cause of 2 No
/ital	ysician; nis certific director, l	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER	P/Outpotiont	Otho	ace of Death (Checker:	k only one) ome 5 Resid	0[7 Other (0)	
on of	nding Phy ath. r: After thi ie funeral c	Certificate: T	TE impation 2 E et	Bb. Time of injury	28c. Injury work?	at	28d. Describe ho			2
ivisio	al or Atte after de Directo d in by th		3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home building, etc. (Specify)	e, farm, stree	et, factory, office		28f. Location (Si City or Town		Number or Rura	l Route Number,
_	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director. After th completed filled in by the funeral	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of examination an only one) 3 Certifying Nurse Practioner: To the best of my knowledge	nd/or investig	gation, in my opinior	n, death occurred at	the time, date ar	nd place, a	and due to the ca	ause(s) and manner stated.
	To the within the complete com		29b. Signature and title of certifier		29c. License	number	2	29d. Date	signed (Month,	Day, Year)
	6		30. Name and address of person who completed cause of death (Item 23	3a) (Type, Pr	int)	hean 4	AA S	cut	e 110	Day, Year) 2011 mble 1045
	Stat	e	31. Date flied (Month, Day, Year) 32. Registrar's Signature 33. According to the state of the	763	O JCh	1120	VC 3		COLUR	12 4045
	Registra		AUG 0 2 2011 Come > 8. Jan	Kal						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 8:45QM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Deatl Himore If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) Social Security Number If Unde 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** Country) C 1 □ M 2 🛂 Months 96 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If fem 27 is marked other than "natural", or from more any injury or other trainment. 10a. State 10d. Inside City Limits 10c. City, Town or Location Completed by Funeral Director 1 Nes 2 No UI timo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2120 . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married 2 A NO Yes 1 Yes 2 1 10 Specify: If Yes, Give 3 Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homen Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၀ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Winnsboro James Harri 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 7 MBR Signatur neral Service Lic Name and Address of Facility tow teia nts Balto. ٢ 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as lardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Dementa Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the Hospital or Attending Physician; The law requires that the death certificate be executed for use as the burial-transit Cause (Disease or linjury ate has been signed by the attending physician and page 2 should be detached for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) 4 Pregnant Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy perform death? 1 ☐ Yes 2 ☐ No Yes completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Hospital: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? Natural injury 5 Pending 1 Natural
2 Accider
3 Suicide 2 🗌 No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined hours a the Funeral Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 24 h (Check only one) 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month, Day, Year) ρ D0069314 7/27/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Woods Rd Partertle MD 21234 Prajapati 8813 Was tham 32 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 30, 2014 7:50 PM Dorothy Virginia Bowers Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Parkville Parkville Baltimore 2900 Alverta Avenue **Funeral** Social Security Number 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8, Date of Birth 9. Birthplace (State or Foreign Min (Month, Day, Year) VOV • 1 • 1917 Hours West Virginia 234-01-6772 Director 93 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Completed by Funeral Director 1 🗆 Yes 2 No Maryland **Baltimore** Parkville 28a-f 10e. Street and Number 23a or 10f. Zip Code 10g. Citizen of What Country? 21234 USA 2900 Alverta Avenue items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces Black, White, etc. White ò 1 Never Married 2 Married 2 XNo ☐ Yes 1 ☐ Yes 2XX No Specify: If Yes, Give "natural" 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Annie John Shade 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code). 1308 Medfield Avenue, Baltimore, Maryland 21211 Paul Bowers, Jr. Department of Health Important: If item 27 any injury or other the 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Lake View Memorial 1 X Burial 2 Cremation 3 Removal from State 8/4/2011 Sykesville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Burgee Henss-Seitz Funeral Home, Inc. 3631 Falls Road, Baltimore, Maryland 23a. Part & Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events burial-transi resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 | retail ucon | Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) 1 Yes 2 No. n signed by the a Id be detached f g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 2 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending iniury work? Accident Investigation 2 🗆 No Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

Box 68760 P.O. Division of Vital Records, Hospital or Attending Physician: Funeral Director: eted filled in by the

Baltimore, Maryland 21215-0036

29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 [only one) 29b. Signa 29c. License number 30. Name and address of person who complete cause of death (Item 23a) (Type, Print) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death le Physician /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner וזוחכ 8. Date of Birth (Month, Day, 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In virs. last birthday) **Funeral** Year) 1 □ M 2 🗓 F Months Days Hours Min. 219-42-0127 67 March 3,1944 Director Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f shov ? Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Mexical Examinar must be notified at Director Md Balto. 1 ☐Yes 2X No Middle River 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Washington Irving Lane 1125 21220 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc 72 hours after 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 □Yes 2X No Specify: White ş 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Secondary (0-12) College (1-4or 5+) 11th <u>Secretary</u> Law Firm permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked other any injury or other traumatic event ones. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Be Salvatore Cimino Magdalina Panzarella ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Johnny M. Barley Spouse 1125 WaSHINGTON Irving Lane Middle River, Md. 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8-2-2011 Gardens of Faith Balto, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek FuneralHome 9705 Belair Road Nottingham, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician End Steph 4848. disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed Sta attending physician and for use as the burial-trar Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) signed by the a P.O. 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by icate has been si 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The After this certificate funeral director, pagperform Division of Vital 2. No 2 No 1 □Yes 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury death. n 24 hours after death.

e Funeral Director: A
bletely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident investigation Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only onel the 29b. Signature and little of certifier

DHMH 17 Rev 1/2001

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

eic.

AUG

31. Date filed (Month)

0 2

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 24425 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last, 2. Date of Death Date Month 3. Time of Death Physician/ Day 3 Year 2:28PM 15 osle Medical a. Facility Name (if not institution, give street Examiner or Location of Death nty of Death LIVIN 6/101 enj 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Hours Min 1 □ M 2 🗷 Director or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a 10c. City, Town or Location, 10d. Inside City Limits Director 1 Yes 2 400 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral .5. 27 13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Race - American Indian. 11. Marital Status rmed Forces? Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No If Yes, Give Year or Dates 3 ₩idowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Kind of Business Indus (Give kind of work done during most of working 100 NOT use pitired) Elementary/96conday (0-12) College (1-4 or 5+) Be Name (First, Middle, Maiden Surname, Father's Name (First, Middle, ဥ GAI formant's Na e/Relationship (Type, Print) homas Jon Baltimore, Method of Disposition 20b. Place of Disposition (Na wn, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Donation Other (Specify) 23a. Part 1. Enter the disea shock, or heart failure e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Deat Ph_sician/ das disease or condition Medical resulting in death) Due to (or as a conseque of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated see or injury Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Anemia month Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Day 5 Other (specify) Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 2 No 1 Yes сотрете filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 1 🗌 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 □ Yes Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending injury 1 Natural 2 🗌 No Accident Investigation within 24 hours after death To the Funeral Director: 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month. Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar Date filed (Month, Bay,-Year)

gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar 24426 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ^{Day} 2011 Dorothy Elizabeth Cutter July 3:44 P M 29 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Carroll Dove House Hospice Center Westminster Social Security Number 1 Year If Under 24 Hrs. If Under **Funeral** 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🕮 88 0472271923 Director 215-16-0890 Mary land Usual Residence of Decedent 28a-f shov 10b Count 10c. City, Town or Location other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director Maryland Baltimore Catonsville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? items 23a 601 Stoney Lane 21228 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Yes 2 X No Yes, Give "natural", or ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3

Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Domestic 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic even John J. Gibbons Helena Latlief 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Crumbacker - Daughter 4616 London Bridge Road Sykesville, Maryland 21784 20b. Place of Disposition (Name of cemetery, crematory or other place)
Crest Lawn
Memorial Gardens 20a. Method of Disposition Date 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 08/03/2011 Marriottsville, Maryland Gardens 21. Signature of Funeral Service Dicensee 22. Name and Address of Facility
Dayid J. Weber Funeral Homes P.A.
5311 Edmondson Avenue Baltimore, Maryland 21229 Part . Enter the disease, or co implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part Immediate Cause (Final Onset and Death Physician Hernour disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Discase or impur that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year g Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been signe page 2 should be Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔏 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed death? Yes Division of Vital 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: မ 1 Yes 2 💢 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Dath 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred Natural ruse 5 Pending Accident 1 🗌 Yes 2 No Investigation within 24 hours after deat To the Funeral Director: 3 ☐ Suicide 4 ☐ Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

297

STONER AVE

21157

WESTMINSTER

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WEL

JOHANNA

31. Date filed (Mo.

			State of State	Maryland /	-			and M		^	0 1		01107
	_		Registrar 1. Decedent's Name (First, Middle, Last)		Cer	tificate of D	Death			Reg. N			24421
	Physicia		Naeb Chhan						2. Date of Dea Month	Day	Ye		3. Time of Death
	Medic Examin		4a. Facility Name (if not institution, give street and number	r)		4b. City, Town, or	Location		JULY A	<u> </u>	20/1		0.20
	Æ		Doctors Community Hospital	L		I	anha	m			Prin	ce (George's
	Funeral Director		5. Social Security Number 6. Sex 7. 219-08-8786	Age (In yrs. last bir 76	rthday) Yrs.	If Under 1 Year Months Days	If Under Hours		8. Date of Birth Month, Day, February	2 ^{year)} 19:	35		olace (State or Foreign atland
	D wo	L	Usual Residence of Decedent 10a. State 10b. County										
	arylan a-f sh fied a	Director	Maryland Prince George's	10c. City, Tow	vn or Loc	Lant	am					11	0d. Inside City Limits 1 ☐ Yes 2 🛣 No
	ihe Ma or 28 e notii	Dir	10e. Street and Number			10f. Zip Code				10a, Citiz	en of Wha	t Coun	
	with 1 s 23a ust b	Funeral	9006 Hilton Hill Terrace			2	20706					mbo	
	death items ner m		11. Marital Status 12. Was Deceder Armed Force	nt Ever in U.S. s?	13. W	/as Decedent of His Yes, specify Cubar	spanic Ori	igin? (Spec	ify Yes or No-	14	4. Race - A		
36	after al", or xami	d by	1 ☐ Never Married 2 🛣 Married Armed Force 1 ☐ Yes 2. If Yes, Give 1 ☐ Yes 1 ☐ Yes 7 ☐ Yes 7 ☐ Yes 7 ☐ Yes 7 ☐ Yes 1 ☐ Yes 2 ☐ Yes 1 ☐ Yes 1 ☐ Yes 1 ☐ Yes 2 ☐ Yes 1 ☐ Yes 1 ☐ Yes 2 ☐ Yes 1 ☐ Yes 2 ☐ Yes 1 ☐ Yes 2 ☐ Yes 1 ☐ Yes 2 ☐ Yes 1 ☐ Yes 2 ☐ Yes 1 ☐ Yes 2 ☐ Yes 1 ☐ Yes 3 ☐ Yes 1 ☐ Yes 3 ☐ Yes 1 ☐ Yes 2 ☐ Yes 1 ☐ Yes 2 ☐ Yes 1 ☐ Yes 3 ☐ Yes 1 ☐ Yes 3 ☐ Yes 1 ☐ Yes 3 ☐ Yes 1 ☐ Yes 3 ☐ Yes 1 ☐ Yes 3 ☐ Yes 1 ☐ Yes 3 ☐ Yes 1 ☐ Yes 3 ☐ Yes 1 ☐ Yes 3 ☐ Yes 1 ☐ Yes 3 ☐ Yes 1 ☐ Yes 3 ☐ Yes 1 ☐ Yes 3 ☐ Yes 1 ☐ Yes 3 ☐ Yes 1 ☐ Yes 3 ☐ Yes 1 ☐ Yes 3 ☐ Yes 1 ☐ Yes 3 ☐ Yes 1 ☐ Yes 3 ☐ Yes 1			☐ Yes 2 🔀 No			,	S	pecify:		sian
ğ	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Completed by	15. Decedent's Education			ent's Usual Occupa			- 1	16b. Kind	d of Busin		
212	in 72 re. han "ı	omp	(Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 of	or 5+)		ind of work done d NOT use retired)	J	it of workin	9				,
2	d with lygien ther ti nt, the	Be C	9			Laborer						oce	ssing
Maryland 21215-0036	ild be filed Mental Hyg narked oth	70 E	17. Father's Name (First, Middle, Last) Chhan Tak – Kham					er's Name rn Po	(First, Middle, N ourng	Maiden Su	irname)		
ary	should and Me is marl raumati		19a. Informant's Name/Relationship (Type, Print)	197	b. Mailine	g Address (Street a				City or To	own. State	. Zip C	Code) 20743
	and 2 st Health a em 27 is ther trai		Tionga Naeb/Daughter										eights, MD
Baltimore,	- 5 E C		20a. Method of Disposition 1 □ Burial 2 X Cremation 3 □ Removal from Sta	20b. Place o	of Dispos	sition (Name of atomeol other place	e)	July Da	ate 31	20c. Loc	ation - City	y or To	wn, State
Ħ	Pa ant ant		4 ☐ Donation 5 ☐ Other (Specify)	Crema	ator	У			2011	-			ryland
Ba	permit. Departr Imports any inji	,	21. Signature of Funeral Service Licensee [M00672	Do:	Name and Addres naldson l 11 Annapo	s of Facili Funer olis	al Ho Road	me & Ci	remat	ory, Maryl	P. and	A. 21113
			23a. Part 1. Enter the disease, or complications that caushock, or heart failure. List only one cause on each	sed the death. Do									Approximate Interval Between
	Physician/	0.1	Immediate Cause (Final disease or condition	PSIS									Onset and Death
	Medical Examiner		resulting in death) Due to (or a	as a consequence	of):	ner	£	Alle	ire				
		ner	Sequentially list conditions, if any, leading to immediate	nter Ern	(office	, , ,	1			1.0			
	executed an and rial-transit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events c	"ERN	11 M	VAL	D.	Ew.	EN 1	IM		\perp	
y	be executed sician and burial-transit	al E	resulting in death) Last Due to (or a	as a consequence	of):	1 1:	(00	. (0					
/60	the the	edical	d	KLIN	20	· G	.500					\pm	
89	certifi nding use as	M/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome	ne of pregnancy						23	3d. Date of	f delive	erv
Rox	requires that the death certifical been signed by the attending p should be detached for use as to	Physician/Me	1 Yes 2 No 4 Pregnan	h 2 Fetal deat it at time of death		Other (specify)	У				Month		Day Year
Д. О.	at the	Phy	g Unknown 9 Unknown Part II. Other significant conditions contributing to deatl		in the ur	nderlying cause give	an in Part	ı	One Did to				e cause of death?
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or d	requi	Completed				-			24a. Was a				osy findings available
Š		omo							autops perfor	med?	prior deat	to con h?	mpletion of cause of
<u> </u>	ian: T rtifica ctor, p	BeC	25. Was case referred to medical examiner?			26. Pla	ce of Dea	th (Check o	_	2 No		Yes	2 🗌 No
5	hysic this ce	မ	1 Yes 2 No Hospital:	atient 2 ER/O			4 🗀 Ni	ursing Hom	ne 5 🗆 Reside	ence 6	Other (S	pecify)	1
0	ding P n. After t funera	Certificate:	1 La Matural 5 La Feriding		Time of injury	28c. Injury work?	at	- 1	3d. Describe ho	w injury o	occurred		
SIO	Attend r deat cctor:	ıţį.	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of I	Injury - At home, fa	arm, stree		Yes 2 🗆		8f. Location (St	reet and I	Number or	Rural	Route Number
Division of Vital Records,	tal or as after all Direction to a side all Direction to a side all all all all all all all all all al			etc. (Specify)					City or Town		varriber er	774745	, real e real ison,
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate completed filled in by the funeral director, pag	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of	f examination and/o	or investig	gation, in my opinio	n, death o	ccurred at the	he time, date an	d place, a	ind due to 1	the cau	ise(s) and manner stated.
	o the vithin 2 o the omple	ž	only one) 3 Certifying Nurse Practioner: To t	he best of my know	vledge, de	eath occurred at the 29c. License	time, date	and place,	and due to the	cause(s) a	and manne signed (Me	r as sta	nted.
	- S F Ó		Immkemil Andelco	am, x		D00	23	981		71			o (l
	0		30. Name and address of person who completed cause or										
	2		Mukemi Abole	112/1	w o	12200Ani	napol	is Rd.,	Duite 229	Glen	in Dal	e, N	11), 20169
	Stat Registra	е	31. Date filed (Month, Day, Year) 32. Regis	strar's Sgnature	e. Kas	1							

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1 Decedent's Name (First, Middle, Last) 2. Date of Death Day 29 Year Month **Physician** 8:10 A 201 0 /Medical Walter Clemmenson Ove 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Franklin Square Hospital
5. Social Security Number | 6. Sex | 7. Age Baltimore center Kose 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1 🔀 M 2 🗆 F Months Director New York 7/21/1931 138-24-2822 80 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show 7 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the final exercities must be a calified at 1 ☐ Yes 2 X No Director Maryland Baltimore Essex 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21221 S. A. 919 Renfrew Street by Funeral 12. Was Decedent Ever in U.S.
Armed Forces?

1 12(Yes 2 □ No
If Yes, Give 195(
Year or Dates: 1954) 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married permit. Pages 1 and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or any Injury or other traumatic event, It a Institut Exami 1950 Maryland 21215-0036 1 □Yes 2 No Specify: 3 Widowed 4 Divorced White 1954 Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) em men son, Military Engineer 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marie Lucille Clemmenson ည Walter Clemmenson Ove Ira 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Essex, Maryland 21221 919 Renfrew Street Rose Ellen Clemmenson (Wife) Itimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20a. Method of Disposition 8/4 2611 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bal Bruzdzinski Funeral Home 1407 Old Eastern Avenue PA Essex, Maryland 21221 Sr. 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician neumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Granulo cytopenia Sequentially list conditions, it any leading to him addata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed physician and the burial-transit Chronic Lymphocytic Leukemia Due to (or as a consequênce of): Box 68760 Physician/Medical attending p for use as use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) signed by the a d be detached for P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ≥ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Disease oronaru s peen s Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate has page 2 1 Yes 2 □ No of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

After the

after death.

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: All

-completely filled in by the fu Medical X State

6 Could not be

determined

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

AUG 0 2 2011

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d, Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

and manner stated.

124356

ause of death (Item 23a) (Type, Print)

field MD, 9000 Franklin Square Drive, Baltimore MD, 21237 32. Registrar's Signature 31. Date filed (Month, Day, Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.										
State of Maryland / Department of Health and Mental Hygiene 1-State Registrar Certificate of Death Reg. 2011 24429											
			Registrar 1. Decedent's Name (First, Middle, Last)			incate of L	Jean	2. Date of Dea	-	3. Time of Death	
	Physicia Medic	al	Helen F.	Curtin	1			July	31, ž	.eo11 9:00 A™	
,	Examin	er	4a. Facility Name (if not institution, give street and number Manor Care	er)			r Location of Death Potomac		4c. County of	Death gomery	
	Funeral		5. Social Security Number 6. Sex 7.	Age (In yrs. la	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt	th 9	Birthplace (State or Foreign	
	Director		578-32-8518	90	Yrs.	Worth Days	Tiodis Will.	December	^y 1 ^y 3 ^{ar)} 1920 P	ennsylvania	
	land show dat	io	10a. State 10b. County	10c. City	y, Town or Loc					10d. Inside City Limits	
	e Mary r 28a-1 notifie	Director	Maryland Montgomery 10e, Street and Number	<u>.</u>	Bet	hesda 10f. Zip Code			10g. Citizen of Wha	1 🗆 Yes 2 💆 No	
	with th	Funeral	8315 North Brook Lane, Ap	t. 201			-2664		United S		
	death items ner mu		11. Marital Status 12. Was Decede	nt Ever in U.S		Vas Decedent of H f Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race -	American Indian, White, etc.	
930	s atter al", or Exami	d by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 If Yes, Give Year or Date	X No		☐ Yes 2 🛚 No			Specify:	White	
2-0	2 hours "natur edical	Completed	15. Decedent's Education (Specify only highest grade completed)			lent's Usual Occup	ation during most of work	king	16b. Kind of Busin	ness Industry	
121	ithin 7 iene. r than the Me	Com	Elementary/Seconday (0-12) College (1-4	or 5+)		ONOT use retired) emaker			Own H	ome	
Maryland 21215-0036	1 and 2 should be filed within 72 hours atter death with the Manyland of Health and Mental Hygiene. if health and Mental Hygiene, item 27 is marked other than "ratural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at other traumatic event,	To Be	17. Father's Name (First, Middle, Last)					,	Maiden Surname)		
ıryla	d Men marke	-	Walter B. Fitzsimmons 19a. Informant's Name/Relationship (Type, Print)		10h Mailir	a Address (Ctroat	Anna	Munley		te, Zip Code) 22192	
Ma	d 2 sho alth an 1 27 is er trau		Thomas E. Curtin, Jr. /Sc	n						, Virginia	
Baltimore,	permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other:		20a. Method of Disposition 1	ate c	emetery, cren	sition (Name of natory or other plac		st 4,	20c. Location - Ci		
ltim	nit. Pag artmen ortant: injury		4 Donation 5 Other (Specify) 21. Signature of Fun rat Service Licensee	Gate		ven Cemeter				ing, Maryland	
Ba	permi Depar Impor any ir		Competer transit	M01305	Ro 75.	bert A. Pun 57 Wisconsi	mphrey Fune n Avenue,	ral Home/ Bethesda,	Bethesda-Ch Maryland 20	nevy Chase, Inc. 0814-3501	
			23a. Part / Enter the disease, or complications that cau shock, or heart failure. List only one cause on each Immediate Cause (Final	ised the deatl line.	h. Do not ente	er the mode of dyin	g, such as cardiac	or respiratory an	rest,	Approximate Interval Between Onset and Death	
200	hysician/ Medical		disease or condition Gastr	ic Lym							
	Examiner	<u>.</u>	Sequentially list conditions, b.								
	ed nsit	Examiner	if any, leading to immediate Due to (or cause. Enter Underlying Cause (Disease or injury	as a consequ	ience of):						
	executed an and rial-transi	1 1	that initiated events resulting in death) Last C. Due to (or	as a consequ	uence of):						
09,	ath certificate be executed attending physician and for use as the burial-transit	Physician/Medica	d								
Box 68760	death certificate be ne attending physic ed for use as the bu	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outco			7			23d. Date	of delivery	
Вох	ed ee	sicia		th 2 ☐ Feta nt at time of c vn		Ectopic pregnand Other (specify)	су		Month	h Day Year	
P.O.	Attending Physician: The law requires that the dea car death. ector. After this certificate has been signed by the a by the funeral director, page 2 should be detached for		Part II. Other significant conditions contributing to dea	th but not res	ulting in the u	nderlying cause gi	ven in Part I.	23e. Did to	obacco use contribu	ute to the cause of death?	
ds, I	requires t been sign should be	ted by	Diabetes					1 🗆	Yes 2 X No 3	☐ Probably 4 ☐ Unknown	
Scor	has be be 2 sho	Completed						24a. Was auto	psy pric	ere autopsy findings available or to completion of cause of ath?	
E Re	ician: The la certificate ha rector, page	0	25. Was case referred to medical			26. P	lace of Death (Chec	1 🗌 Yes		Yes 2 □ No	
Vita	hysicia his cert I direct	70 B			ER/Outpatier	nt 3 🗆 DOA Oth	er:	, ,	dence 6 🗌 Other ((Specify)	
n of	ding P h. After t funera	cate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation (Month,	injury Day, Year)	28b. Time of injury	work		28d. Describe h	now injury occurred		
	er deal rector: by the	Certificate:	3 Suicide 6 Could not be	Injury - At ho		eet, factory, office		28f. Location (S City or Tov		or Rural Route Number,	
Ö	Hospital or 24 hours afte Funeral Dir sted filled in	SalC	29a. Certifier 1 X Certifying Physician: To the bes			accured at the time	data and place a			as stated	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certific completed filled in by the funeral director,	Medical	(Check (Check only one) Certifying Nurse Practioner: To	of examination	n and/or inves	tigation, in my opini	on, death occurred	at the time, date a	and place, and due to	o the cause(s) and manner stated.	
	To the within 2 To the сотрые		29b. Signature and title of certifier		14	29c. Licens			29d. Date signed (#		
	0		Thomas M Mast 30, Name and address of person who completed cause				J 34		August	1, 2011	
	8		Thomas M. Masterson, M.I	685	58 Old	Dominion	Drive,	Ste. 104	4, McLean	, Virginia 22101	
	Sta Registr	te ar	31. Date filed (Month, Day, Year) AUG 0 2 2011	istrar's Sigra	par	Les .					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State of Maryla				Mental Hy	giene		
			1 - State Registrar	rtificate of Death			Reg. 2011 24430			
	Physicia	in/	1. Decedent's Name <i>(First, Middle, Last)</i> Lajpat Rai Chopra				2. Date of De Month	o, Day 011 Year	3. Time of Death 3:15 P M	
L,	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		•	4c. County of Death			
	ZAGIIII	Brighton Gardens				Rockville			ery	
ī	Funeral				If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Y			h 9, Bir	thplace (State or Foreign	
	Director		625-96-5847	Yrs.	,		April Da	1924 In	dia	
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director		City, Town or Lo					10d. Inside City Limits	
			Maryland Montgomery		N. Bet	hesda			1 ☐ Yes 2 🛣 No	
			10.9.0 C. G. L. L. T. T. 11. G. L. L. L. L. L. L. L. L. L. L. L. L. L.	Hall Street. #302				10g. Citizen of What Co	,	
99			10306 Strathmore Hall Street, #302 20852 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)				pecify Ves or No.	United States No- 14. Race - American Indian,		
			Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No				o Rican, etc.)	Black, Whit		
003		ted	3 ☑ Widowed 4 ☐ Divorced If Yes, Give Year or Dates.		1 ☐ Yes 2 🔀 No			Specify: AS	Tan-Indian	
15-		To Be Completed	15. Decedent's Education (Specify only highest grade completed) [Give kind of work done during most of working life. DO NOT use retired)				king			
212			Elementary/Seconday (0-12) College (1-4 or 5+)		ditor			Indian Go	overnment	
pu			17. Father's Name (First, Middle, Last)					Maiden Surname)		
z			Charan Das Chopra Shanti Devi Puri							
Ma			19a. Informant's Name/Relationship (Type, Print) Vinod K. Chopra/Son					r, City or Town, State, Zi .11e,CA 94:		
Baltimore, Maryland 21215-0036			20a. Method of Disposition 20b.	Place of Dispo	osition (Name of	}	Date 2,	20c. Location - City or		
			1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	ntgome emator	itum, Inc.	20	11	Bethesda,	Maryland	
Bal	permit Depar Impor any in once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase Bethesda, Maryland 20814. 7557 Wisconsin Avenue							
п			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between							
The way	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death) Onset and Death Onset and Death						Onset and Death	
است	requires that the death certificate be executed seen signed by the attending physician and hould be detached for use as the burial-transit		Due to (or as a consec	. ,	free				months	
		dical Examiner	Sequentially list conditions, if any, leading to immediate cause Erbert Unserlying. Due to (or as a consections)						Monens	
			Cause (Disease or iinjury that initiated events c. Heart Fa						years	
_					idney Disease				years	
3760			d							
Box 687		y Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnant 1	2 Fetal death 3 Ectopic pregnancy				23d. Date of de	23d. Date of delivery Month Day Year	
Bo			in the past 12 months? 1 Yes 2 No 9 Unknown In the past 12 months? 4 Pregnant at time of 9 Unknown					Month		
P.O.									the cause of death?	
ds,		ted b	Advanced Dementia 1 Yes 2 X No 3 Probably 4 Unknow							
COL		Completed by	autopsy prior						topsy findings available completion of cause of	
Re	n: The ficate r, pag		25. Was case referred to medical				1 🗆 Yes	rmed? death? 2 k No 1 Ye	s 2 🗆 No	
/ita	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has the completed filled in by the funeral director, page 2 seconditions.	To Be	examiner? 1 Yes 2 No 1 Inpatient 2	T EB/Outpation	Otho	r:		аПон п		
of			27. Manner of Death 1 ☑ Natural 5 ☐ Pending (Month, Day, Year)				ibe how injury occurred			
ion		Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	injury	M 1 Yes 2 No					
Division of Vital Records,			4 ☐ Homicide determined 28e. Place of Injury - At r building, etc. (Speci	home, farm, street, factory, office 28f. Location (S City or Tow			Street and Number or Rural Route Number, yn, State)			
		Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated							
),	the lithin 2 the Formula the F		only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as sta 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, E						stated.	
	⊢≤⊭ँँ		Aummit Alyto, 406	griature and the of certifier August 29c. License number 29d. Date signed August						
			30. Name and address of person who completed cause of death (Iter					1 04 5 4 5		
		Щ	Summit Gupta, MD 3000 North F			cott Cit	y, Mary	land 21043		
State Registrar AUG 0 2 2011 Registrar's Signature August 1. Date filed (Month, Day, Year) August 2. Registrar's Signature										

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend Item# I, per phy, g918 8-12-11 sm. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Edward James Cackoski 2. Date of Death Physician/ Edward 2045 M ackowski 2611 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundai Annayoris Anne Medical Center Anundel County Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth Days 1**XX**M 2 □ F Months Min. (Month, Day, Hours 475-32-6109 81 **Director** Minnesota 930 July Usual Residence of Decedent 28a-f show 10a. State 10b. County aţ 10c. City, Town or Location Director 10d. Inside City Limits "natural", or items 23a or 28a-f s idical Examiner must be notified 1 Yes 2 No Maryland Anne Arundel Co. Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1697 Dunstable Green 21401 United States 12. Was Decedent Ever in U.S.
Armed Forces?

1XX Yes 2 No 1951-11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ۾ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 🗓 No Specify: If Yes Give 3 X Widowed 4 ☐ Divorced 1954 Completed Specify: White traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) than " Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene, is marked other tha 12 Bowling Center Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Mika Cackoski Alexandra Woiina and 2 should to Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trat Mr. Edward G. Cackoski / Son 1697 Dunstable Green Annapolis, MD 21401 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 8/2/2011 4 Donation 5 Other (Specify) New Cathedral Cem. Baltimore, Maryland Signature of Funeral Ser 22. Name and Address of Facility Singleton Funeral & Cremation M01121 Services PA; 1 2nd Ave SW; Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or comprications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Retween Immediate Cause (Final Onset and Death √h sician/ disease or condition resulting in death) Congestive neart Medical Due to (or m a consequence of): Examiner Valvular disease Sequentially list conditions. Examine if any leading to immedicause. Enter Underlying Due to for sela consequence on Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery in the past 12 months? Month Pregnant at time of death Day Year ed by the at detached for Yes 2 No g 🗌 Unknown g 🔲 Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ٥ 23e. Did tobacco use contribute to the cause of death? Completed 1 ☐ Yes 2 🔼 No 3 ☐ Probably 4 ☐ Unknown After this certificate has been si funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 A No 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Other: ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA □ Nursing Home 5 □ Residence 6 □ Other (Specify) Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Matural 5 Pending 1 🗌 Yes Accident Investigation the within 24 hours after deatl To the Funeral Director: 6 Could not be 3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) 7203 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12ebecca Medical Parkway 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** obest eutsch en 3:15 07 2011 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Oakcrest Village Parkville 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 X M 2 □ F 89 Yrs Feb 18, 1922 Pennsylvania Director 189-14-1453 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Experience must be notified at 1 ☐ Yes 2 XNo Director Maryland Baltimore Parkville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21234 8800 Walther Boulevard, Apt-3018 USA Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 kg Yes 2 □ No 1943
If Yes, Give
Year or Dates: 1945 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2X No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Engineering Electrical Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Schmidt 2 Julius Deutschendorf 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12009 Hunting Tweed Drive Owings Mills, MD 21117 James Deutschendorf,Son Department of Heall Important: If item 2 any injury or other once. 20c. Location - City or Town, State Pages 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory Inc. 07/30/11 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licensee Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Cancer Malignant **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day 5 ☐ Other (specify) ☐Yes 2☐No signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 ☐ Yes 2 ☐ No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred or Attending 1 Natural
2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours af To the Funeral D completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State

Division of Vital Records,

Schero

Baltimore, ober

> Registrar DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ronal Jeffreys 8800 Wki Hner Boule

32. Registrar's Signature

H005Z365

8800 Walther Boulevard, Parkville Mayland 21234

07-29-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For State State Registrar	of Maryland / Depa	artment of H tificate of D			iene 2011	24433
	Physicia		1. Decedent's Name (First, Middle, Last)	Dupre			2. Date of Death	26 Day 2011 Year	3. Time of Death 11:30 p M
	Medic Examin		4a. Facility Name (if not institution, give street and nu 2745 Urey Road		4b. City, Town, or White I			4c. County of Dear Harford	i
	Funeral Director		5. Social Security Number 6. Sex XX M 2 G	7. Age (In yrs. last birthday) 54 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth April 1. Day		thplace (State or Foreign
	ıryland a-f show fied at	I - 1	Usual Residence of Decedent 10a. State 10b. County MD Harford	10c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 💥 No
	th the Ma 3a or 28a t be noti	Funeral Director	10e. Street and Number 2745 Urey Road		10f. Zip Code 21161		1	log. Citizen of What C	ountry?
36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the <u>Medical Examiner must be notified at once.</u>		11. Marital Status 12. Was Dec	s 2 K No live	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Spe in, Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whi Specify:	
Maryland 21215-0036	nin 72 hours ne. ihan "naturi e Medical E	Completed by	15. Decedent's Education (Specify only highest grade complete	d) 16a. Deced	OO NOT use retired)	during most of worki	ing	16b. Kind of Business Police D	
land 21	be filed witlental Hygier rked other i ic event, th	To Be C	17. Father's Name (First, Middle, Last) Roger L. Dupre			18. Mother's Name	a	Fiori	
Mary	2 should Ith and M 27 is mar		19a. Informant's Name/Relationship (Type, Print) Karen Dupre (Spouse)			and Number or Rura		City or Town, State, Z	
Baltimore,	Page 1 and nent of Hea int: If item iry or othe		20a. Method of Disposition 11 → Burial 2 ☐ Cremation 3 ☐ Removal fro 4 ☐ Donation 5 ☐ Other (Specify)	Highview	matory or other place. Cemetery	08/0	Date 01/11	Fallston,	Maryland
Balti	permit. 8 Departm Importa any inju		21. Signature of Funeral Service Licenses		610 W. Ma	cPhail Ro	ad, Bel	Air, MD	me, Bel Air 21014
	Physician/ Medical Examiner		23a. Part 1. Enter the disease, or complications the shock, or heart failure. List only one cause on Immediate Cause (Final disease or condition resulting in death)	at caused the death. Do not enteach line. Stage to (or as a consequence of):	ter the mode of dyir	conce	or respiratory arre	h	Approximate Interval Between Caset and Death
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ivisio	I or Attendi after death. Director: A	Certificate:	3 Suicide 6 Could not be determined	ace of Injury - At home, farm, suilding, etc. (Specify)			City or Tov		
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	To the within To the comp	2	29b. Signature and title of cepting.						
0			30 Name and address of person who completed of the complete of the comple	ause of death (Item 23a) (Type	e, Print) 602 S.A	TWOOD	RD STE	E200 B	7/2011 Pel Air MD21015
	St Regist	ate	31. Date filed (Month, Day, Year) AUG 0 2 2011		backer				

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760 6

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		For State Registrar		State	of Mary	iand / L		artment of F tificate of L		i Mental H	ygien Reg. N	20		2443	4
Physicia	n/	1. Decedent's Nam		, Last) kstein		***				2. Date of D Month July	eath	27,	Ž011	3. Time of Deat	
Medic Examin		4a. Facility Name (if			ımber)			4b. City, Town, o	r Location of De				y of Death	12:10 Z	7 M
نر		Bel Air He						Bel Air	T 1511-3 0411		_	Harfo			
Funeral Director		5. Social Security N 214–22–368	3	6. Sex 1 ☐ M 2 K F	7. Age (In)	yrs. last birti 86	nday) Yrs.	Months Days	If Under 24 H Hours Mi		irth Day, Yea <i>r</i> 18, 1	925	Balti	place (State or Fore ntry) More, MD	eign
and show 1 at	or	Usual Residence of 10a. State	Decedent 10b. County		100	c. City, Town	or Loc	ation						10d. Inside City Lim	nits
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	382 Beverl						10f. Zip Code 32951				S.A.	What Cou	ntry?	
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urs afte .ural", c	ted by	3 Widowed		If Yes, G Year or D	ive		1	☐ Yes 2 X No	Specify:			Specify	. Whit	e	
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should should rama raumat		19a. Informant's Na				1		g Address (Street						Code)	
and 2 Health tem 27		Mrs. Annet 20a. Method of Disp	position		21	0b. Place of	Dispos	everly Ct.	1	Dato				own, State	
Page 1 ment of ant: If i ury or o		1 🗌 Burial 2.4	Cremation 5 C Other (S)	3 ☐ Removal from pecify)	m State	vans f	vijer el A	ar ^{ry} Crapel ^{lac} ir	ce) Aug	ust 03, 2011				/aryland	
permit. Depart Import any inj		21. Signature of Fu	neral Service Li	cense Jeffra	y -	sterman)1543)	EV	Name and Addre	s of Facility a	& Crematic	n Ser	viœs	- Bel	L Air	
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Attendir death	Certificate:	2 Accident 3 Suicide 4 Homicide	Investig 6 Could r determi	ation not be 28e. Place	e of Injury - A	At home, far	m, stre	M 1 🗆	Yes 2 No	28f. Location	(Street a	ınd Numb	er or Rura	I Route Number,	
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To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director.	Medical	(Check 2	Medical Ex	Physician: To the caminer: On the bathursey ractioner	asis of examin	nation and/or	r investi	gation, in my opinio	n, death occurre	d at the time, date	and place	ce, and du	e to the ca	use(s) and manner s	stated.
To th within To th comp		29b. Signature and		1				29c. License	number				d (Month,		
		30. Name and add	ess of person w	ho completed cau	use of death	(tem 23a) (1	Type, Pi		3902			91	yly /	28,201	1
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ John W. Ehman, Jr. July 27 2011 6:15 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death MD Masonic Home Cockeysville Baltimore Social Security Number If Under 24 Hrs. Birthplace (State or Foreign Country)
 MD 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** 1**X** M 2 □ F Hours (Month, Day, Year, Director 213-16-4693 92 IulvUsual Residence of Decedent . Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

Rant: If item 27 is marked other than "natural", or items 23a or 28a-f shov jury or other traumatic event, the Medical Examiner, must be notified at jury or other traumatic event, the Medical Examiner, must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 ☐ Yes 2 🗓 No Baltimore Cockeysville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 300 International Circle 21030 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces' Black, White, etc. Completed by 1 Never Married 2 X Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify. white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Sales Executive Aggregate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ John Walter Ehman Catherine Frances Knox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald R. Ehman/son River Dr., Titusville, NJ 08560 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of h Important: If ite any injury or ot once. cemetery, crematory or other place, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ion 5 Other (Specify Druid Ridge Cemetery 7/30/11 Pikesville, MD Bryan W. Clary 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley, Inc.
10 W. Padonia Rd., Timonium, MD 21093 23a. Part 1 Enter the disease, or complications that ca shock or beart failure. List only one cause on each used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Immediate Cause (Final Onset and Death Physician/ Cardio Vascular Haute disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examine Due to (or as a consequence of): if any, leading to immediate Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? hio CHF 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has performed? Yes 2 N 2**9Z**No 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) 2 **A**No Hospital ᇛ Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 40 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Cate of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 1. Natural 5 \square Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined within 24 hours a To the Funeral L Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

13×11

Registrar
DHMH 17 Rev 7/2009

State

Banh

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

3508

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 31, Day 2011 Year 4:30 A M Bruce Duane Everett Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Baltimore Gilchrist Hospice Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 **X**M 2 □ F Days Hours Min. 0272311957 585-62-1577 54 NH Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Harford Bel Air 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Funeral 23a 1309 Sweetbriar Lane 21014 USA permit. Page 1 and 2 should be filed within 72 hours after death \
Department of Heatth and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner m. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian. rmed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married ģ 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2xxxx No Specify: Specify: White 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Duron Paint Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Jordan John Everett Wanda Lou 19a. Informant's Name/Relationship (Type, Print)

Elena L. Everett (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code).
1309 Sweetbriar Lane, Bel Air, MD 21014 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State . Page 1 s cemetery, crematory or other place)
Atlantic Crematory 1 Burial 2 X Cremation 3 Removal from State 08/01/11 Glen Burnie, MD 4 Denation 5 Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home, Bel Air 610 West MacPhail Road, Bel Air, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Ancen disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify 2 - No Certificate: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b, Time of 28c. Injury at 1 Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Box 68760 P.O. Records, Division of Vital within 24 hours after death. To the Funeral Director. After

29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles St. Balto. md 21204

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July 29, Day 2011 Physician/ 9900 M P Ellison Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Severn 755 Rosewood Road If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) Funeral **X**X M 2 □ F Min. Months Days Hours 1472571966 MD 217-90-5815 Director 44 Usual Residence of Decedent 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits aţ **Funeral Director** traumatic event, the Medical Examiner must be notified 1 Yes 2 XXVo Anne Arundel Severn MD10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number **USA** 21144 755 Rosewood Road permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items: any injury or other traumatic event, the Medical Examiner musonce. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes XX No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 White 1 Yes XX No Specify: Specify: 3 Widowed XX Divorced Completed Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Chemical 12 Mechanical Engineer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Reininger Russell Ellison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brooklyn, MD 21225 22 Ballman Court Ms. Jamie Ellison / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ☐ Burial XX Cremation 3 ☐ Removal from State 8/1/2011 Glen Burnie, MD Atlantic Crematory 4 Donation 5 Other (Specify) 22. Name and Address of Facility Singleton Funeral & Cremation Services, PA 1 2nd Ave SW Glen Burnie, MD 21061 220 complications that crused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Fnter the dise art 1 shock, or heart failure. List Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ resulting in death) Medical Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Physician/Medical Examiner 3310N Cause (Disease or linjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Year Day Pregnant at time of death Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To Be Completed by 2 No 3 Probably 4 Unknown 1 Tes Division of Vital Records, Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? death? 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ieral Director: After th filled in by the funeral 27. Manner of Death 28a. Date of injury (Month. Day Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 Natural e18 HUNG 2 XNo 28/11 1 Tes Investigation Accident 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office determined building, etc. (Specify) City or Town, State) tome severn within 24 hours : To the Funeral L Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier cause of death (Item 23a) (Type, Print) of person who completed ONRS 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygien Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 11:27pM Tishman 30 Harold 2011 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 719 Maiden Choice Lane HR 644 Catonsville Baltimore If Under 1 Year If Under 24 Hrs. Min. A Date of Birth (Month, Day, Year) Mar. 8, 19 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F 1924 148-16-2534 87 New Jersey Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. Count or 28a-f show the Medical Evandoer must be notified at 1 ☐ Yes 2 No Director Maryland **Baltimore** Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 719 Maiden Choice Lane HR 644 21228 United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Tyes 2 No 1943-14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 KNo Specify: Specify: 3 Widowed 4 □ Divorced If Yes, Give Year or Dates: White þ Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Upper Management 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) is marked of Pages 1 and 2 should be Solomon Fishman Ethel Spodek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health item 27 i Ann Fishman / Daughter 5105 S. Rolling Rd., Halethorpe, Maryland 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1 Department of H Importent: If ite eny injury or ot once. 1 → Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. View Cemetery 08/03/2011 Baltimore, Maryland 21. Signature of Funeral Service Licensee Alyson K Taylor 22. Name and Address of Facility MacNabb Funeral Home, P.A. 301 Frederick Rd., Catonsville, Maryland 21228 23a. Part1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Preumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): or Attending Physicien: The law requires that the death certificate be executed burial-transit that initiated events physician and resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 4☐ Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Triknown Completed Dementia 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No Advanced Fibrilla ti Atrial 1 Yes 2 ₽ No After this certitic funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA Certification; To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No death. I Director: A investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide hours after within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifier 2000 mn 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21228 Maiden Deneen Bowlin, ma 711 Chaice

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

lavaid Firdaus		S I- For State Registrar	tate of Maryla		artment o ertificate o		d Mental H	-	eg. No. 201	1 24439
Physiciar Medical Examin	1/	Decedent's Name (First, Mide	dle,Last)	1	_		-	2. Date of Dea Month	Day Year	3. Time of Death 0456 hrs
medical Examine		Javaid 4a. Facility Name (if not instituti	on, give street and nur	nber)	F	irdaus 4b. City, Town, or I	ocation of Death	July 31, 2	4c. County of I	
		Baltimore Washingto				Glen Burnie			Anne Arur	ndel
Funeral Director		5. Social Security Number 220–41–0251	6. Sex	7. Age (In yrs. 62	last birthday) Yrs	If Under 1 Year Months Days	If Under 24Hrs Hours Min			9. Birthplace (State or Country)
	ŀ	Usual Residence of Decedent	125 2	ŲŽ.		<u> </u>		110 .	31 40	
w any		10a. State 10b. County		10c. City	, Town or Locat	ion				10d. Inside City Limits
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or 28a		313 Thelma A	1770				061		0g. Citizen of What	•
with th	<u>-</u>	11. Marital Status	12. Was Dece			s Decedent of Hisp	panic Origin? (S		U.S.A - 14. Race - A	American Indian, Black,
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s after ral", unier	2		vorced If Yes, Give Year or Dates:	21	1	Yes 2 X No			Specify:	Asian
2 hour "netu	Completed	15. Decedent's Education (Spe Elementary/Secondary (0-12)				t's Usual Occupationst of working life.			16b. Kind of Busin	ness/Industry
036 ithin 7 ne.		12th grade	2yr	s	Cal	o Drive	c		Cab Co	mpany
	3	17. Father's Name (First, Middle	, Last)					, ,,	Maiden Surname)	
	- L	Abdul Karim 19a. Informant's Name/Relations	ship (Type, Print)		19b. Mailing		Nazeerr		nber, City or Town,	State Zin Code)
and 2 shou lealth and N tem 27 is n troumatic		Zeeshan J. G	Shauri-So	n	4					
re, M s 1 and 2 : f Health a ff item 27 cr treum	- F	20a. Method of Disposition		20b.	Place of Dispos crematory or oth	ition (Name of cem ner place)	etery,	Date	nie Md 20c. Location - Ci	ity or Town, State
Baltimore, ocrmit. Pages 1 ar Department of He Important: If ite injury or other tr	ı,	4 Donation 5 Other S	pecify:		ing Mer	norial E	Park 8/	/1/2011	Woodla	wn, Md
Baltimore, MI permit. Pages I and 2 s Department of Health a Important: If Item 27 injury or other treum	1	2 Signature of Funeral Service	Licenspe	L	Mai	ame and Address	West			
Physician	+	23a Part I. Enter the disease, or	complications that car	used the death	43(n. Do not enter th	OO Wabas ne mode of dying, s	sh Ave such as cardiac o	Balti r respiratory arr	more, M est, shock, or heart	Approximate Interval
/M icul Examiner	1	failure. List only one cause Immediate Cause (Final disease	01 (11)	es						Between Onset and Death
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i		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a c	consequence o	of):					
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60, Rescuted system and burial - transit		UNPENDED	d AMENDED							
376C ficate g phys		F FEMALE: 3b. Was decedent pregnant in t	23c. If yes, ou	utcome of preg		al death 3	Ectopic pregna	nov.	23d. Date of de	
Box 6876 e death certificate the attending phy ed for use as the l		past 12 months?	4 Pregna	nt at time of de		aldeath 3 _ ner (Specify)	coopic pregna	псу	World	Day Year
D.O. Box 6876 that the death certificat ned by the attending phedetached for use as the by the Dhyel clant.	<u>"</u>	1 Yes 2 No 9 Un	known 9 Unknow					Topo Did to	hassa usa sastribud	te to the cause of death?
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Records, The law requires ficate has been signage 2 should be							· · · · · ·	24a. Was a		re autopsy findings available
Recol The law icate has page 2 sl						· · · · · · · · · · · · · · · · · · ·		autop perfor 1 Yes	med? deat	r to completion of cause of th? Yes 2 No
ital Recion: The certificate rector, page		25. Was case referred to medica					of Death (Check		2 110	Tes Z NO
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Division of Vital Records, P.O. Box 6876(tal or Attending Physicien: The law requires that the death certificate its after death. *I Director: After this certificate has been signed by the attending physicien by the funeral director, page 2 should be detached for use as the beat fifteation: To Re Completed by Physician/Mac	<u> </u>	27. Manner of Death 1 Natural 5 Pend	28a. Date of Jul 31, 20	f Injury Day,Year) ITT	28b. Time of Ir 0140 hrs				now injury occurred auto collision	
/iSic or Atte her dea hirecto n by th			stigation 28e. Place	of Injury - At h	ome, farm, stree	t, factory, office bui				or Rural Route Number, City
Division of spital or Attending tours after death, neral Director: Aft filled in by the function:		4 Homicide dete		Major Roa	d / Highway			or Town, Si Route 3 and R	tate) Loute 424, Croftor	n, MD
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	- 1 2		hysician: To the best miner: On the basis of and manyer sta	examination a						
F 3 F 8	2	9b. Signature and title of certifie				29c. License			29d. Date signed	(Month, Day, Year)
4			//			O.C.M	l.E.		July 31, 2011	
OCME		0. Name and address of levson Mary G. Ripple VD.	who completed cause Deputy Chief M			W. Baltimore	Street, Baltin	nore, MD 21	223	
State Registra		11. Date filed (Month, Day, Year) AUG 0 2 2011	32. Reg	istrar's Signati	ire Gilla					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month 07/20/2011 <u>Linda Marie</u> Green Medical 5:00a 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 2702 Keyworth Ave Apt 110 Baltimore Baltimore 5. Social Security Number 9. Birthplace (State or Foreign Country)
MD 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8 Date of Birth 1 🗆 M 2 🗶 F Days Hours **Director** 57 216-62-8593 28a-f show 10a State 10c. City, Town or Location other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director MD Baltimore Baltimore 1 X Yes 2 □ No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 2702 Keyworth Ave Apt 110 21215 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 Lycau trent of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Median once. 1 ☐ Yes 2X No Specify: Specify: Black Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 yrs College (1-4 or 5+) Assembly Line Worker Gov't <u>Contractor</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James B. Green Edna Mae Gillespie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary L. Nickens Sister MD 21666 1004 Love Point Road Stevensville 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Atlantic Crem 4 ☐ Donation 5 ☐ Other (Specify) 7/21/2011 Glen Burnie MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Simplicity Crem & Fun Serv ThomasAllenPA 7090 Ridge Rd Hanover MD 23a. Part 1, Enter the disease. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caus n each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or linjury that initiated events resulting in death) Last burial-tran attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death 9 Unknown 9 Unknown P.O. 23e. Did to coo use contribute to the cause of death? þ Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 1 ☐ Yes 2 ☐ No Yes Division of Vital To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Hospital or Attending 24 hours after death. Natural 5 Pending Accident 1 ☐ Yes 2 ☐ No. Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature

Registrar

State

person who completed cause of death (Item

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 2011 1:17 PM Grady J414 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimure Baltimone JEWART If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Date of Birth (Month, Day, **Funeral** Months Days Hours Year) 1√2 M 2□ F 218-44-0750 Director 10 64 02 NC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Meckel Experience must be recified at 1 X Yes 2 ☐ No Director MD Baltimore NA 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number within 72 hours after death with 21223 U.S.A. 2106 Penrose Ave Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give 14. Race - American Indian Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2√2 No Specify: Specify: ģ Black 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cab Driver Taxi Service 12th grade na 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be finance of the second sec Be Carlene Everett Walter Lee Grady Sr. ೭ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2106 Penrose Ave, Baltimore, Md 21223 of Health a Carlene Grady-Mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1 Department of It Important; If it any Injury or c 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet 8/4/2011 Owings Mills, Md ature of Funeral Service Licenses 22. Name and Address of Facility March F/H West 21. Sign 4300 Wabash Ave, Baltimore, Md 21215 23a. Par 1. Enter the Usease, or complications that complex shock, or heart failure. List only one cause on each line. the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death Immediate Cause (Final AMEROSCLELOTIC Heart **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (cries a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last physician and the burial-trans The law requires that the death certificate be execu Due to (or as a consequence of): Physician/Medical the attending posterior IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) □Yes 2□No 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably Donknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe certificate 2 No 1 ☐ Yes 1 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this ၉ 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 5 Pending investigation 1 Natural

Division of Vital Records, P.O. Box 68760

Hospital or Attending Physician: n 24 hours after death.

■ Funeral Director: A pletely filled in by the fi death. completely the within 7

State Registrar

Medical

2 Accident

3 Suicide

29a, Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

en, no Name and address of person who completed cause of death (Item 23a) (Type, Print) MD

6 □ Could not be

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year) 2011

28f. Location (Street and Number or Rural Route Number, City or Town, State)

and manner stated.

Bullimure Street Bullimure, Maryland 21223 JULY WEST

32. Registar's Sig

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien

			1 - State Registrar	Certificate of Death	7 Reg	ZUII 24442
П	Physicia	ın/	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year 3. Time of Death
-	Medic	al	Rita V. Giordani 4a. Facility Name (if not institution, give street and number)	1 (b) Ob T	July 27	2011 12:56 A ^M
	Examin	er	Gilchrist Center	4b. City, Town, or Location Towson	on or Death	4c. County of Death Baltimore
	Funeral	ĵ	5. Social Security Number 6. Sex 7. Age (In yrs. last bit	thday) If Under 1 Year If Und	ler 24 Hrs. 8, Date of Birth	Birthplace (State or Foreign
	Director		220-14-1278	Yrs. World Bays Hours	Min. (Month, Pay, Ye Aug 9,	1925 Maryland
	land show dat	tor		n or Location		10d. Inside City Limits
	Mary 28a-f otifie	irec	Maryland Baltimore Tim	nonium		1 ☐ Yes 2 X No
	th the 3a or t be n	ral D	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Country?
	ath wi ems 2 r mus	Funeral Director	5 Glenamoy Road 11. Marital Status 12. Was Decedent Ever in U.S.	21093 13. Was Decedent of Hispanic C	Origin? (Specify Yes or No-	USA 14. Race - American Indian,
9	fter de , or its amine	by	1 Never Married 2 Married 1 Yes 2 No	If Yes, specify Cuban, Mexic	can, Puerto Rican, etc.)	Black, White, etc.
Maryland 21215-0036	ours af tural" al Exe	Completed	3 X Widowed 4 Divorced If Yes, Give Year or Dates.	1 🗆 Yes 2 🗶 No Specia	fy: 	Specify: White
-51:	72 hc in "na Medic	mple	15. Decedent's Education 16a (Specify only highest grade completed)	 Decedent's Usual Occupation (Give kind of work done during mo life, DO NOT use retired) 	ost of working	b. Kind of Business Industry
212	within giene. er tha , the l		Elementary/Seconday (0-12) College (1-4 or 5+) 12 n/a	Homemaker		Own Home
pu	e filed tal Hy ed oth event	To Be	17. Father's Name (First, Middle, Last)	18. Mot	ther's Name (First, Middle, Mai	den Surname)
r <u>y</u> la	uld be d Men marke natic		Mariano Sabatino			Gugluizza
Ma	12 sho Ilth an 27 is r trau			b. Mailing Address (Street and Num 22 Beloak Court,		
re,	1 and of Hea item		20a. Method of Disposition 20b. Place of	of Disposition (Name of		ic. Location - City or Town, State
ii.	Page ment (ant: If ury or		La Bariar 2 - Grandation 6 - Normovar norm State	ery, crematory`or other place) ey Valley Memoria		imonium, Maryland
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. (garden of Fun all Service Lights)	22. Name and Address of Fac	ility	
	40200	-	23a. Part . Enter the disease or complication, that caused the death. Do	10 W. Padonia	Road, Timoniu	nney Valley Inc. im, Maryland 21093
in.	Ph_sician/		shor k, or heart failure. List only one cause on each line.	.11 0 21	o -	Interval Between Onset and Death
	Medical		disease or condition resulting in death) Due to (or as a consequence	of:	ea	
	Examiner	_	Sequentially list conditions, b.			
	pe tisi	min	if any, leading to immediate cause. Enter Underlying Gause. Enter Underlying Gause (Unsease or injury)	of):		
	xecut	Exa	that initiated events resulting in death) Last C. Due to (or as a consequence	of):		-
00	ificate be executed g physician and as the burial-transit	Medical Examiner	d			
98760	rtificat ling ph e as th	<u> </u>	IF FEMALE:			
Box 6	attendii for use	Physician/	23b. Was decedent pregnant in the past 12 months? 1 Ver 2 No. 1	h 3 Ectopic pregnancy 5 Other (specify)		23d. Date of delivery Month Day Year
-	the de	hysi	in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	J Citie (Specify)		
P.0	requires that the de been signed by the should be detached	by P	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Par	rt I. 23e, Did tobac	co use contribute to the cause of death?
rds,	een się	sted	Colombia You Dis Good		1 🗆 Yes	2 No 3 Probably 4 Unknown
000	has b	Completed by	augestive Heart to	ilue	24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of death?
Ä	sician: The law certificate has t lirector, page 2 s		25. Was case referred to medical	00 Plant (P	performe	No 1 Yes 2 No
Vita	is certific director,	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/O	Other:	eath <i>(Check only one)</i> Nursing Home 5 Residence	e 6 XOther (Specify) HOLDICP
of	ding Ph h. After th funeral		27. Manner of Death 28a. Date of injury 28b.	Time of 28c. Injury at work?	28d. Describe how i	
sion	ttendi death. stor: A y the fu	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	M 1 ☐ Yes 2 ☐		
Division of Vital Records,	al or A s after I Direc d in by		4 ☐ Homicide determined 28e. Place of Injury - At home, fa building, etc. (Specify)	ігт, street, тастогу, опісе	28f. Location (Stree City or Town, S	t and Number or Rural Route Number, tate)
_	Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and sted filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier Physician: To the best of my knowledge,	death occured at the time, date and	d place, and due to the cause(s) and manner as stated.
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completed filled in by the		(Check 2 Medical Examiner: On the basis of examination and/conly one) 3 Certifying Nurse Practioner: To the best of my know 29b. Signature and title of certifier	ledge, death occurred at the time, da	ite and place, and due to the car	use(s) and manner as stated.
	5.≥6 8		29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)
	'	\$	30. Name and address of person who completed cause of death (Item 23a) (T = D : 0		1-2(-1)
			Philip Shaheen, 6701 N. Ch	celes 8t - Sui	te 4105, B	althouse, MD 21204
	State Registra	_	31. Date filed (Month, Day, Year) 82. Registrar's Signature	backel	,	1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 12:08P.M. George L Gallagher Medical Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Glen Washington Medical Center Burnie Anne Arunde Social Security Numbe 6. Sex 1**XX**M 2 □ F If Under 1 Year If Under 24 Hrs 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Country) 214-24-7224 1/15/1928 Director 83 MD Usual Residence of Decedent show 10a. State 10b. County items 23a or 28a-f shoner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2XXNo MD Anne Arundel Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21144 USA 1449 Virginia Avenue 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, permit. Page 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner Black, White, etc. Completed by 1 Never Married 2 Married XX Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify Specify. XX Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Balt. City Fire Dept. 10 Lieutenant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Harry Gallagher Anna Koon 19a. Informant's Name/Relationship (Type, Print) Son Step 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gambrills, MD 21054 957 Gambrills Lane Mr. Kendall A Browning, Sr. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 8/2/2011 4 ☐ Donation 5 ☐ Other (Specify) Brooklyn, MD Cedar Hill Cemetery e Licensee 22. Name and Address of Facility Singleton Funeral & Cremation M01220 Services, PA 1 2nd Ave SW Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ 1 disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or linjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed burial-tra Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No the hed t ed by tl signed k Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 3 Probably 4 ☐ Unknown 1 Yes 2 No Completed peen 24a. Was an Were autopsy findings available prior to completion of cause of After this certificate has funeral director, page 2 autopsy performed? Yes 2 No death? 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Tes 2 X No Other: ည 1 Mnpatient 2 -ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural within 24 hours after death.

To the Funeral Director: Afte completed filled in by the fun-5 Pending work? 2 🗌 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) Q 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print

State Registrar 31. Date filed (Month, Day, Year)

02

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 7 30 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 7200 N. ALTER ST. BALTIMORE GWYNN OAK Social Security Number If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday, **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day) Months Davs Hours Min. Director WEST VIRGINIA 219-22-5908 Usual Residence of Decedent "natural", or items 23a or 28a-f show SIBSON 10a. State 10b. County 10c. City. Town or Location with the Maryland the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Xyes 2 □ No MD. BALTIMORE GWYNN OAK 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7200 N. ALTER ST. 21207 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: BLACK 3 X Widowed 4 Divorced Specify: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) -12--6-SUPERVISOR GOVERNMENT Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked 2 ISIAH BEARD MARY LAWSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21133 NATHANIEL GLBSON (SON) Important: If item 27 4300 BREEDERS CUP CIRCLE RANDALLSTOWN, MARYLAND 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3
Removal from State Injury o DRUID RIDGE CEMETERY 8-5-2011 4 ☐ Donation /5 ☐ Other (Specify) BALTIMORE, MARYLAND 21. Signatur - Honeral Service Licensee JONATHAN HIBNER Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. D. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part 1. E. ler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoo, or heart failure. List only one cause on each line Interval Between Immediate use (Final disease or condition resulting in death) Onset and Death Physician avdiac Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine any, leading to immediate cause. Enter Underlying Cause (Disease or linjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Pregnant at time of death signed by the at Id be detached for Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ No Completed 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law autopsy performe Director: After this certificate 1 Yes 2 No Yes completed filled in by the funeral director, 25. Was case referred to medica Certificate: To Be 26. Place of Death (Check only one) 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4
Nursing Home Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 2 Accident injury 5 Pending 1 Yes 2 No Investigation Could not be Suicide 6 [28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier mbe 29c. License nu ompleted cause of death (Item 23a) (Type, Print 30. Name and address of 31. Date filed (Month, Day, State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month
JULY Physician/ 29 2011 $02:00A^{M}$ SAMUEL GILLER Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner CARROLI CARROLL HOSPITAL CENTER WESTMINSTER 8. Date of Birth Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday, **Funeral** 1 🛛 M 2 🗆 F Months Days Hours 03/10/1918 MD 216-07-7770 93 Director Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10c. City, Town or Location with the Maryland "natural", or items 23a or 28a-f sho Director 1 🗌 Yes 2 ី No MD BALTIMORE REISTERSTOWN 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 3691 CLYDESDALE ROADWAY 21136 Page 1 and 2 should be filed within 72 hours after death wment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 X Married 2 No Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give 3 🗌 Widowed 4 🗌 Divorced WHITE Year or Dates. or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 SALESMAN FOOD Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ WEISBERG ISIDOR GILLER CELIA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MICHELE KEDZIERSKI / DAUGHTER 3691 CLYDESDALE ROADWAY, REISTERSTOWN, MD 21136 20a. Method of Disposition
1

→ Burial 2
→ Cremation 3
→ Removal from State Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 4 ☐ Donation 5 ☐ Other (Specify) HEBREW YOUNG MEN 08/01/2011 WOODLAWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD, PIKESVILLE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RENAL ALSEASE Physician END STAGE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence oi). use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Day Pregnant at time of death signed by the arild be detached f 2 🗌 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by the Hospital or Attending Physician; The law requires 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy performed? death? v de 1 Yes 2 100 Yes 2 1 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 | Ne မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral or 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b Time of Certificate: 28d. Describe how injury occurred Natural 5 Pending ☐ Accider☐ Suicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar M DHMH 17 Rev 7/2009 29b. Signature and title of certifier

5480 31. Date filed (Month, Day, Year)

AUG 0 2 201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

129501

29d. Date signed (Month, Day, Year)

447, EAST MAIN ST. WESTMINSTER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 24446 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ $J_{\mathbf{u}}^{\mathsf{Month}}$ 6:30 P M 29, 2011 Ruth R. Hopkins Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Catonsville Baltimore Renaissance Gardens If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 🗆 M 2 💢 F Months Days Hours Oct 20, 1918 Virginia 92 Yrs 229-09-6945 Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland notified at Director 1 Tes 2 X No Catonsville Maryland Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ms 23a or must be n Funeral 21228 709 Maiden Choice Lane RG N 213 USA items death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status the Medical Examiner Armed Forces?

1 Yes 2 No ō 1 Never Married 2 Married δ Maryland 21215-0036 be filed within 72 hours after 1 ☐ Yes 2X No Specify. If Yes, Give Year or Dates Specify: White "natural", Completed 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Public School System Librarian Department of Health and Mental Hyginportant: If item 27 is marked othe any injury or other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Bertha Bowman Marion J. Ritchie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marietta, GA 30067 161 Shadowland Road William Lohr Green, Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 08/01/11 ²² Name and Address of Facility Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 21. Signature of Funeral Service Licens Thomas Gregor 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Be Completed been si should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy this certificate has ral director, page 2: Yes 2 No or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 🗌 Yes 2. No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 Yes 2 No Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred After injurv 5 Pending the Hosping.
Ithin 24 hours after death.

o the Funeral Director: Aft Natural Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) the Hospital Medical Lectifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one within To the 29b. Signature and title of certi

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print

Caree, Cotoun

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DORIS EMMA HERBERT 28 5:00 PM July 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Center Buenie ANNE Glen Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F 217-20-8475 Hours June 4, 1926 Country land 85 Director Usual Residence of Decedent or 28a-f show notified at 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Maryland Anne Arundel 1 Yes 2 X No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 309 Seventeenth Avenue Funeral 21225 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) and Mental Hygiene.
Is marked other than "natural", or iten raumatic event, the Medical Examiner. 14. Race - American Indian, Armed Forces? Black, White, etc ģ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify. Specify: White Completed 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Eastern Box Co. **Bundler** Be 17. Father's Name *(First, Middle, L*ast) **Edward Laser** 18. Mother's Name (First, Middle, Maiden Surname) 2 Eleanor Berlin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Branham (Daughter) 309 Seventeenth Avenue, Baltimore, Maryland 21225 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State Cedar Hill Cenetery 8/1/2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McCully—Polyniak Funeral Home, P.A. 237 East Patapsco Avenue, Baltimore, Maryland 21225—1856 Signature of Fun al Service Licensee Kevin E Ecker 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death PNOWMONIA Ph_sician/ HSPIRMIN disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury the Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi that initiated events resulting in death) Last and Due to (or as a consequence of): 24 hours after death. From this certificate has been signed by the attending physician. Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown Day Month Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 1 No 1 Yes Yes 25. Was case referred to medical examiner?

1 Yes 2 No completed filled in by the funeral director, Be 26. Place of Death (Check only one) Other: မြ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 Natural 5 Pending injury 1 Yes 2 No Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the only one) 29b. Signature and title of certifie 29c. License number 10055 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CEMPUTL MEDILM AWMONE WASUING 31. Date filed (Month, Day, Year) State AUG 0 Registrar

DHMH 17 Rev 7/2009

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Division of Vital Records, P.O. Box To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director After this certificate has been signed by the after the funeral Director After this certificate has been signed by the after the formal director and all the performances of the performance o	E p	ٽ ح		Ì										etetad
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DHMH 17 Rev 7/2009

11-05597 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2011 Mary Margaret Hoffman 1- For State Certificate of Death Registrar 1, Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Da July 26, 2011 1804 hrs **Medical Examiner** Mary Margaret Hoffman 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Baltimore County** 1505 Woodcliff Avenue Catonsville 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or **Funeral** 5215-56-2991 Foreign Maryland Country) Months Day Hours Director 1 M 2 F 66 1945 Unk. Mar Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 Yes 2 X No or 28a-f show Catonsville l other than "natural", or items 23a or 28a-f shothe Medical Examiner must be notified at once. Maryland Baltimore Director 10e, Street and Number 10g. Citizen of What Country? 1505 Woodcliff Avenue 21228 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces 1 Never Married 2 Married Yes 2X No specify: White 4 Divorced If Yes, Give Yee 1 Yes 2 No specify: 2 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done Baltimore, MD 21215-0036
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22. Name and Address of Fecility
Cremation Society Of Maryland, Inc.
299 Frederick Road Baltimore, Maryland
at caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart

A 21. Signature of Funeral Service Liver Thomas Gregor roman 23a. Part I. Enter the disease, or comp Approximate Interval **Physician Retween Onset and** failure. List only one cause on each line. /Medical Death a Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and ledical AMENDED, 23a, 27, per me, 9919 9-15-11 sm #5perFH, G919, 9/20/2011, WS attending physician a UNPENDED P.O. Box 68760. an/Me 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Month Day Year past 12 months? 4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 ✔ Unknown icate has been signed by the att page 2 should be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 虿 1 Yes 2 No 3 Probably 4 Unknown Completed Division of Vital Records, 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed? death? ✓ Yes 2 No 2 No certificate 1 Yes To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifi 26.Place of Death (Check only one) director, 25. Was case referred to medical examiner? Other Nursing Home 5 Residence 6 Other: Scene Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No 28a. Date of Injury (Month, Day, Yea 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 X Natural Pending 1 Yes 2 No filled in by the 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Sal 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) unes O.C.M.E. July 27, 2011 30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 24450 State of Maryland / Department of Health and Mental Hygiene [= State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1:18 P_M Alice Frances Handley July 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Good Samaritan Hospital Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🗶 F Months Days Hours (Month, Day, 219-32-9955 75 **Director** 1935 Ohio Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits Director MD Baltimore 1 XYes 2 No 10e. Street and Number 10f. Zip Code 5 10g. Citizen of What Country? by Funeral 2908 Berwick Avenue 23a 21234 United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, the Medical Examiner Armed Forces?

1 Yes 2 No Black, White, etc. ō 1 Never Married 2 Married Maryland 21215-0036 "natural", Yes Give 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Lockheed Martin Executive Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Frances Ann Burns should be file h and Mental H is marked of ည Earl Tamplin, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sl it of Health a : If item 27 is Frederick Handley, III/Son POBox 135041 Big Bear Lake, CA 92315 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State August 3, Department of Important: If it any injury or c 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Parkville, Maryland Parkwood Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2011 Signature of Funeral Service Licensee Evans Funeral Chapel & Cremation Services 8800 Harford Road, Parkville, Maryland 21234 Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Approximate Interval Between Immiliate Cause (Final PNEUMONIA ASPIRATION Physician/ 10 DAYS dis/ ase or condition ulting in death) Medical Due to (or as a consequence of): Examiner 10DAUS 1POGTACEMIC GCKCHK COPATTHY Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying attending physician and for use as the burial-transit Cause (Disease or iinjury DIABGTES MELLITUS that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 mo ths?
1 Yes 2 No Month Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by NSTEMT 1 Yes 2 No 3 Probably 4 Unknown DIABOTIC KETO AUDOIL 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy ADRIK STENOSIS. 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? To the Funeral Director; After this certific completed filled in by the funeral director, To Be 26. Place of Death (Check only one) Hospital 1 Tyes Other: ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred the Hospital or Attending 5 Pending Natural injury work?
1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature a RES 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BWD 21239 LOCH 5601 31. Date filed (Month, Day, Year,

DHMH 17 Rev 7/2009

Registrar

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 8:38 P.M James July 30 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford County 1706 Ruff Mill Road Bel Air If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** 1**X** M 2□ F Months Days Hours Min. 72 219-36-0795 March 11,1939 Maryland Director Usual Residence of Decedent death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Bel Air 1 ☐ Yes 2x No Maryland Harford County Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 1706 Ruff Mill Road 21015 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married Married Specify: White 1□Yes 💥 No Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Ryland Homes 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Ann Mohr John Huber ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1706 Ruff Mill Road, Bel Air, Maryland 21015 Loretta Huber (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place)

Evans Funeral Chapel Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 08/01/2011 Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Evans Funeral Chapel & Cremation Services—Belair 3 Newport Drive, Forest Hill, Maryland 21050 21. Signature of Funeral Service Licensee Jes TUM Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Metasta month **Physician** one disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 4 tens Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760, that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day in the past 12 months? 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 27. Manner of Death 28d. Describe how injury occurred Hospital or Attending 24 hours after death. 1-Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide thin 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated. To the within 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 11

Ştate Registrar

31. Date filed (Month, Day, Year) 32. Begistrar's Signature

AUG 0 2 2011 August 5. Sparks

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ashkan Bahrani

602 S. Atwood Road, Bel Air, Maryland 21014

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

mend item 1 per doc g918 8-8-11 yt.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) Ruby Curry 2. Date of Death Harris Month Day Year **Physician** 22:08 PM 30 1147 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore** 8. Date of Birth (Morth Day) 933 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 219-32-9746 1 □ M 2 🗹 F 3 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. If Item 27 Is marked other than "natural", or Items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be notified at MD 1 ¥Yes 2 ☐ No Director more 10f. Zip-Code 21aaa 10e. Street and Number 10g. Citizen of What Country? Funeral **Examiner must** 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married 21215-0036 1 ☐ Yes 2 ☑ No Specify. þ Blac 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation other traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 17. Father's Name (First, Middle, Last) Baltimore, Maryland Mother's Name (First, Middle, Maiden Be De elia lae 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Re lationship (Type. Print Battimore 2057 vanessa 19hter 20a. Method of Disposition 20b. Place of Disposition (Name of Jemetery Grematory or other place) Location - City or Town, State permit. Pages
Department of H
Important: If Ite
any Injury or of 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ocense i ces 9. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heal 4 filure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ATHEROSCLEROTIC VASCULAR /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed nding physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 - Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) 2 No P.O. 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, TRAHSOLANT 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? HYPER TENSIO LL 24a Was an autopsy 2 No 2 No 1 TYes 1 Tyes of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 \sum Nursing Home ၉ 5 Residence 6 Other (Specify) this completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Division Injury 1 Natural 5 Pending investigation death. 1 Tes 2 🗌 No 2 Accident after death 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location. (Street and Number or Rural Route Number. determined 4 Homicide 24 hours a Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D63303 つ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 Eastern Avenue, Baltimore, MD, 21224 MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

DHMH 17 Rev 1/2001 11595

Registrar

AUG 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Ju1y 27, 2011 11:07P Catherine A. Houston Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Stella Maris Timonium Balto. 7. Age (In yrs. la 5. Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year -16-1932 Maryland 1 □ M 2 X F Days Hours Min Director 213-28-4026 Usual Residence of Decedent show 10c. City, Town or Location 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at Director 28a-f Md. Balto. Essex 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral "natural", or items 23a 210 Cove Road 21221 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic agent. þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: White Specify Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore, Maryland 2121 Elementary/Seconday (0-12) College (1-4 or 5+) 12th Medical Center Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles J. Schmehling Catherine M. Knauff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DTR. Deborah J. Brazil 5209 Bush Street White Marsh, Md. 21162 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ⊠ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8-1-2011 Gardens of Faith Balto.Md. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Road NOttingham, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition PANCREATIC CANCER Medical resulting in death) Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Ulsease or injury and I-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ▼ No 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy Day Year Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 X No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 - No 2 🕱 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 X No P 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE within 24 hours af er death.

To the Funeral Director: After the completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending 1 \sum Yes 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifies (Check only one 29b. Signature and title 29d. Date signed (Month, Day, Year, npleted cause of death (Item 23a) (Type, Print) JACKIE JONES, CRNP 2300 DULANEY VALLEY RD.

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Morith, Day, Year)

p.m.

TIMONIUM, MD 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryland /		rtment d			nd M		_	2 N I		24454
			Registrar 1. Decedent's Name (First, Middle, Last)	0071	mouto	, ,	Juli	Т	2. Date of Dea	Reg. N		•	3. Time of Death
	Physicia		Frances L. Hartman						July 3	31, ^D	^{ay} 2011	Year	9:30 A ^M
	Medic Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Tov	vn, or L	ocation of	Death			c. County o	of Death	7.00
			6257 Darlington Court		Fı	ede	rick				Fred	lerio	ek
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birt	thday)	If Under 1 `Months D		If Under 2	4 Hrs. Min.	8. Date of Birt	h (Voor)		9. Birthp	place (State or Foreign
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<u>5</u>	"2 hol	Completed	15. Decedent's Education 16a. (Specify only highest grade completed)	(Give k	ent's Usual C ind of work d	one dui	ion ring most o	of workin	ıg .	16b.	Kind of Bus	siness Inc	dustry
12	thin 7 sne. than he M	No.	Elementary/Seconday (0-12) College (1-4 or 5+)		NOT use rea Homema	. ′					Oran	. Ноп	10
0 0	ed wi Hygid Sther ent, t	Be (17. Father's Name (First, Middle, Last)		HOMEMA			's Name	(First, Middle,	Maider		11011	16
Maryland 21215-0036	be fil ental ked (2	James Mead						es Pavl		r ourname,		
ary	s mar		19a. Informant's Name/Relationship (Type, Print)	o. Mailine	g Address (Si	reet an	d Number	or Rural	Route Number	r, City o	or Town, Sta	ate, Zip C	Code)
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ore,	of He fitem		20a. Method of Disposition 20b. Place o	f Dispos	sition (Name of atory or othe	of r place)			ate	20c.	Location - 0	City or To	wn, State
<u>ĕ</u>	Page nent ant: I		1 Burial 2 □ Cremation 3 □ Removal from State Cremate 4 □ Donation 5 □ Other (Specify) Parkla	-	-		: 🗗	ugus 201	st 6,	Ro	ckvil	1e,	Maryland
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee William G. Tunshuer M01173	Ro	Name and A	ddress P ur	of Facility nphrey	Fune	eral Home	e, R	ockvil	le, I	nc.
			23a. Part 1. Enter the disease, or complications that caused the death. Do n						respiratory arr		Le, Mai	rytan	Approximate
١,	Physician/		shock, or heart failure. List only one cause on each line.										Interval Between Onset and Death
	Medical		disease or condition resulting in death) End Stage F Due to (or as a consequence or consequenc		I Dise	ase						-	Months
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s,	uires l sigr Ild be	q pe							1 🗆 🕻	Yes 2	2 🔯 No - 3	B Prob	oably 4 🗆 Unknown
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ō	tendi leath ior: A the fu	ifica	2 Accident Investigation			_	es 2 🗆 N						
Division of Vital Records,	al or Attendir s after death. Il Director: Af ed in by the fu	Certificate:	4 Homicide determined 28e. Place of Injury - At home, fa building, etc. (Specify)	ırm, stre	et, factory, of	fice		2	8f. Location (S City or Tow			or Rural	Route Number,
	pital ours a eral (29a. Certifier 1 X Certifying Physician: To the best of my knowledge,	death o	coursed at the	time d	tate and ni	ace and	I due to the car	100(c) 3	and manner	as state	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	(Check 2 Medical Examiner: On the basis of examination and/conly one) 3 Certifying Nurse Practioner: To the best of my know	or investi	gation, in my	opinion,	, death occ	urred at	the time, date a	nd plac	e, and due t	to the cau	use(s) and manner stated.
	To th Comp	~	29b. Signature and title of certifier	J ., 4.	29c. Li			1			ate signed		
			I Clay Talana MI	1		D37:	197			A·	ugust	1,	2011
			30. Name and address of person who completed cause of death (item 23a) (Type, Pr	rint)							-	
0 _V	<u> </u>		Alan Rohrer, M.D. 15 W. 7th Stre	et,	Frede	ric	k, Ma	iry1a	and 21	701			
	Stat Registra	e ar	31. Date filed (Month, Day, Year) AUG 0 2 2011	bar	les of								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 20a7 Vera Virginia Hibberd M Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Glen Burnie Baltimore Washington Medical Center If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) g. Birthplace (State or Foreign 8. Date of Birth **Funeral** Hours Min July 17, 1926 MaryTand **Director** 85 220-12-2094 Usual Residence of Decedent 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. and: If item 27 is marked other than "natural", or items 23a or 28a-f sho and to 47 is marked other than "natural", or items 23a or 28a-f sho up or other traunatic event, the Medical Examiner must be notified at ury or other traunatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2X No Maryland Anne Arundel Glen Burnie 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 21060 312 Phelps Ave Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2X No Black, White, etc. þ 1 Never Married 2XX Married Baltimore, Maryland 21215-0036 1 Yes 2XX No Specify If Yes, Give Year or Dates Specify: white Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 11 Liquor Dept. Manager Pharmacy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Elizabeth Ross Wolff Otto 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit, Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once. MD 21060 <u>312 Phelps Ave Glen Burnie,</u> Mr. Raymond Hibberd/ Husband 20a. Method of Disposition 20b. Place of Disposition (Name of JulyDate 29 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 【▼ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2011 Glen Burnie, MD Atlantic Crematory 22. Name and Address of Facility Singleton Funeral & Cremation Ivan 1 2nd Ave SW Glen Burnie, MD 21061 Services PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final neumonia Onset and Death Pnysician/ disease or condition Medical Examiner resulting in death) Due to (or as a consequence of) Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events Due to (or as a consequence of) attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? After this certificate 1 🗌 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) 2 1 No Other: 1 🗌 Yes မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Tyes 2 No Investigation Could not be s after death Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral C Medical Vertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a Certifier (Check

HIBBERD,

DHMH 17 Rev 7/2009

State Registrar 3

ne and address of person who complete

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

20V1

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Manyland / Department of Health and Mental Hydiene

		1	For State State Registrar	e of Maryland		artment of H tificate of D		ivientai Hy	Reg. No	2011	24456
	Physicia		1. Decedent's Name (First, Middle, Last) Thomas	Ireland	4			2. Date of Dea Month Jules	ath Dar 2	y Year 1 20 (1	3. Time of Death 14:54 PM
٥	Medic Examin		4a. Facility Name (if not institution, give street and Harbon Hospi +al	number)		4b. City, Town, or Baltin		 	_	County of Deat	
-	Funeral Director		5. Social Security Number 6. Sex 1 M 2 \square	7. Age (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		th 30,1	g. Birt	thplace (State or Foreign
	how at.		Usual Residence of Decedent 10a. State 10b. County		, Town or Lo	cation					10d. Inside City Limits
	Marylar 8a-f sl	Director	Maryland N/A	Ва	ltimo	re					1 🏿 Yes 2 □ No
	h the Na or 2 be no	al Di	10e. Street and Number			10f. Zip Code			10g. Cit	tizen of What Co	ountry?
	ath wit	Funeral	1737 Clarkson Street 11. Marital Status 12. Was D	Decedent Ever in U.S.	. 13. \	2123 Was Decedent of His f Yes, specify Cubar		Specify Yes or No-		U.S.A.	rican Indian,
036	e filed within 72 hours after death with the Manyland that Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ρ	1 Never Married 2 M Married 1 Never Married 1 If Yes,	Forces? es 2 🗷 No Give or Dates.		f Yes, specify Cubai		rto Rican, etc.)		Black, White	
Maryland 21215-0036	72 hour	Completed	15. Decedent's Education (Specify only highest grade comple	ted)	(Give	dent's Usual Occupa kind of work done d O NOT use retired)		orking	16b. K	and of Business	Industry
212	within 7% giene.		Elementary/Seconday (0-12) Colleg	e (1-4 or 5+) 5	me. D	Lawyer			Sta	te of M	aryland
and	ntal Hy ed oth event	To Be	17. Father's Name (First, Middle, Last) John		Irela	nd	18. Mother's Name	ame <i>(First, Middl</i> e,	Maiden		Murrav
aryl	should be file and Mental 7 is marked or raumatic eve	113	19a. Informant's Name/Relationship (Type, Print)		_	ng Address (Street a			er, City or	Town, State, Zij	o Code)
Ž,	ge 1 and 2 should be it of Health and Men If item 27 is marke or other traumatic		Dorothy L. Ireland (Wi			Clarksor	1 Street				
nore	Page 1 a nent of H ant: If ite ury or otl		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal 1 4 □ Donation 5 □ Other (Specify)	rom State C6	emetery, crer	sition (Name of natory or other plac n Mem. Pl		Date /02/2011		ocation - City or on Burni	e, Maryland
Baltimore,	permit. Page 1. Department of Important: If it any injury or or or once.		21. Signature of Funeral Service Licensee	lgrei							1and 21230
			23a. Part Enter the disease, or complications t shock, or heart failure. List only one cause of	nat caused the death						e, Mary	Approximate Interval Between
	Ph, sician/		Immediate Cause (Final disease or condition	oronary	arte	y dis	ease				Onset and Death
-	Medical Examiner		Due	to (or as a commque	ence of):	J					
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	cate be executed physician and s the burial-transi	Exar	Cause (Disease or iinjury that initiated events resulting in death) Last C. ———————————————————————————————————	e to (or as a conseque	ence of):						
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. Box 687	Attending Physicians. The law requires that the death certificate be executed or death. sctor. After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit.	≥	in the past 12 months?	outcome of pregnar Live Birth 2 Fetal Pregnant at time of d Jnknown	Ideath 3	Ectopic pregnand Other (specify)	Э У			23d. Date of de Month	live r y Day Year
s, P.O.	ires that the signed by id be detact		Part II. Other significant conditions contributing Diabetes, Hyper !		-						o the cause of death? Probably 4 D Unknown
Division of Vital Records,	The law requate has beer page 2 shou	Completed by	Atrial Riboration					24a. Was auto	psy ormed?	prior to death?	utopsy findings available completion of cause of
tal F	ician; The certificate rector, pag		25. Was case referred to medical examiner?				ace of Death (Ch		2 2 10	0 10	
of Vi	Physic r this c eral dire	은	27. Manner of Death 28a. I		28b. Time o		4 L Nursing	Home 5 Resi			cify)
on o	ending eath. or: Afte he fune	Certificate	2 Accident Investigation	Month, Day, Year)	injury	work			,		
ivisi	l or Attu after de Directo			lace of Injury - At hor uilding, etc. (Specify)		eet, factory, office		28f. Location (City or To			ıral Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director After this certific completed filled in by the funeral director.	Medical	29a. Certifier 1 Certifying Physician: To to (Check 2 Medical Examiner: On the only one) 3 Certifying Nurse Practio	e basis of examination	and/or inves	tigation, in my opinio	on, death occurre	ed at the time, date	and place	e, and due to the	cause(s) and manner stated.
	To th within To th comp	-	29b. Signature and title of certifier	MD		29c. License	e number		29d. Da	ate signed (Mont	h, Day, Year)
	•		30. Name and address of person who completed Dr. Mandris Sarrafi,	cause of death (Item	23a) (Type, I						
	Sta			32 Augistrar's Signat	ure			, , ,			, ,
	Registr	ar	AUG 0 ≈ 2011 /	Warre &	1. 190	ale					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Jďiÿ 28, 2011 Maria Johnson 1:00 P. M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2301 Warfield Drive Forest Hill Harford Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth

Jan 199, 1933 **Funeral** 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1 🗆 M 2 🔀 F Months Days 590-06-8596 Argentina 78/rs. **Director** Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** Maryland Harford 1 Yes 2XXNo Forest Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2301 Warfield Drive 21050 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 X Yes 2 ☐ No Specify: 3 Widowed 4 Divorced Specify: Hispanic Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Healthcare and Mental Hygier is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be Carlos Gallo Norberta Bubico 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Mrs. Laura Davids (Daughter) 2301 Warfirld Drive, Forest Hill, Maryland, 21050 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Evans Fureral Chapel August 1, 2011 4 Donation 5 Other (Specify) Forest Hill, Maryland Testerman 22. Name and Address of Facility
(M01543) Evans Funeral Chapel & Cremation Service-BelAir
3 Newport Drive Forest Hill, Maryland 21050
Approximate 21. Signature of Funeral Service Licensee Jeffrey R. P rt . nt de disease, or complications that caused shock, or le rt failure. List only one cause on each line ne disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Immediate Cause (Final Electro maprelic Discessociation. Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of). use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ for Month 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To Be Completed by en bubsens Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform Division of Vital Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certific 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident filled in by the 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) acterdo a 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar S. Rosqueraj, mo

31. Date filed (Month, Day, Year)

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21015

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Johnson Harcourt 23:26 M 28 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Baltimore Hospital 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** 1 X M 2 □ F Months Days 261-26-2103 Director 86 11-23-1924 FL Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show other traumatic event, the Pedical Examinar must be notified at Director 1 XYes 2 □ No BALTIMORE WOODLAWN 28a-f 10e. Street and Number 10f, Zip Code 10g, Citizen of What Country? ō 3510 ESSEX ROAD 21207 USA 23a death v Funeral or items, 12. Was Decedent Ever in U.S. Armed Forces?1 XYes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗶 №o Specify þ Specify: 3 X Widowed 4 □ Divorced BLACK 'natural", Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, It allow Elementary/Secondary (0-12) College (1-4or 5+) 4+ CHEMIST US GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ည **ENAS JOHNSON** JULIA SMITH 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GLORIA CANDAY/DAUGHTER 76 PIOUS RIDGE RD. BERKELEY SPRINGS, WV 25411 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CROWNSVILLE VET.CEM. 8-4-2011 CROWNSVILLE, MARYLAND 21. Signature of Funeral Service Licenses 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 1701-31 LAURENS ST. BALTIMORE, MD 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** renal failure disease or condition resulting in death) /Medical Due to (or as consequence of): Examiner static colorecta meta Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence on physician and s the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): signed by the attending physician and be detached for use as the burial Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) P.O. ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an autopsy performed? 1 □Yes 2 M2No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 MNo has page 2 certificate Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 28c. Injury at Work? After 1 Natural 5 Pending n 24 hours after death.

The Funeral Director: A pletely filled in by the funeral pletely filled in death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 1 29b. Signature and title of certifier. 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar

KIM 31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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29 2011

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			State Registrar		Certificate of			Reg. N 201	1 24459
	Physicia Medic		1. Decedent's Name (First, Middle, Last) Ethe	Jacobs			2. Date of D		Year Year Year Year
رسد مرک	Examin		4a. Facility Name (if not institution, give street	et and number)	4b. City, Town, c	11	Death -	4c. County of	of Death N/A
P	Funeral Director		E. Coolel Coough, Number C. Co.	7. Age (In yrs. last birtho	Months Days			irth lay, Year) O. 1942	Birthplace (State or Foreign Country)
	show d at	tor	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town o	or Location				10d. Inside City Limits
	the Mary or 28a-f	Funeral Director	10e. Street and Number	Ba	10f. Zip Code	rl_		10g. Citizen of W	1 Yes 2 No
	ath with t	uneral	3016 May+			2121		L	LSA
9600	ould be filed within 72 hours after death with the Maryland do Mental Hygiene. marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates.	13. Was Decedent of H If Yes, specify Cuba 1 Yes 2 No	an, Mexican, Specify:	n? (Specify Yes or No Puerto Rican, etc.)		- American Indian, K, White, etc.
21215-0036	within 72 ho giene. er than "na the Medic	Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Seconday (0-12)	completed) (0	ecedent's Usual Occup live kind of work done ie. DO NOT use retired	during most of		16b. Kind of Bus	siness Industry
Maryland 2	ild be filed v Mental Hyg iarked othe atic event,	To Be	17. Father's Name (First, Middle, Last)	Wilson		-	's Name (First, Middle	e, Maiden Surname)	nan
	2 sh shar 7 is trau		19a. Informant's Name/Relationship (Type, I	196. N 1500 39	Aailing Address (Street	and Number	or Rural Route Numb	er, City or Town, Sta L, BAI	ate, Zip Code) How MD 21215
Baltimore,	Page 1 ment of tant: If it iury or o		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Ren 4 ☐ Donation 5 ☐ Other (Specify)		isposition (Name of crematory or other place	ce) e	B 5 2011	20c. Location - 0	City or Town, State
Ba	permit Depart Import any inj once.		21. Signatur Funeral Service Licensee	Indeed Se	22. Name and Addre	ss of Facility	Howell 18 km.	Balt	mare, tome
P	h _{sician/}	i o	23a. Part 1. Enter the disease, or complicat shock, or heart failure. List only one call mmediate Cause (Final disease or condition	ions that caused the death. Do not use on each line.	enter the mode of dyir	ng, such as ca Lmi	ardiac or respiratory a	rrest,	Approximate Interval Between Onset and Death
-/	Medical Examiner	L.	resulting in death) Sequentially list conditions, b.	Due to ras a consequence of):	ry o Pat	hy			
	executed ian and irial-transit	Examiner	if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	Ty Re d	2 Dia	bete	25		
	i a e	- 1	resulting in death) Last	Due to (or as a phrsequence of):	2				
. Box 68/60	To the hospital or Attending Physician; the law requires that the death certificate be within 24 hours affect ceatt. To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but the but the funeral director.	Physician/Medica	in the past 12 months?	If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 ☐ Ectopic pregnand 5 ☐ Other (specify)	су		23d. Date Mon	e of delivery tth Day Year
ds, P.U.	quires unat u en signed by ould be deta	þ	Part II. Other significant conditions contrib	uting to death but not resulting in t	he underlying cause gi	ven in Part I.		V	bute to the cause of death?
Records,	cate has be ; page 2 sho	Completed					24a. Was auto perf 1 \square Yes	opsy pr ormed? de	lere autopsy findings available rior to completion of cause of eath? ☐ Yes 2 ☐ No
VITAI	lysician lis certifi director	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	oital: 1 ☐ Inpatient 2 ☐ ER/Outpa	- 4 Oth	er:	(Check only one) sing Home 5 ☐ Res	idence 6 🗆 Other	(Specify)
on or	ath. ". After the funeral		27. Manner of Death 1 ★ Natural 5 □ Pending 2 □ Accident Investigation	28a. Date of injury (Month, Day, Year) 28b. Tim inju	ry work	y at	28d. Describe	how injury occurred	
DIVISION	ita of Aive ins after der al Director lec in by th	al Certificate:	4 11 Hornicide determined	28e. Place of Injury - At home, farm. building, etc. (Specify)			City or To	wn, State)	r or Rural Route Number,
Hoen	in 24 hou in 24 hou he Funer	Medical	(Check 2 \(\subseteq Medical Examiner: \)	n: To the best of my knowledge, dea On the basis of examination and/or in actioner: To the best of my knowled	vestigation, in my opinio	on, death occi	urred at the time, date	and place, and due t	to the cause(s) and manner stated.
ام ا	with com		29b. Signature and title of certifier	J	29c. License	e number	148	29d. Date signed	(Month, Day, Year) 28-2011
~ (Do.		30. Name and address of person who compl	eted cause of death (Item 23a) (Tyr	pe, Print)	I E.	Universi-	ty Parke	May Palto
	State Registra		31. Date filed (Month, Day, Year)	32. Registrar's Signature			2,	0	7 2413 21218

DHMH 17 Rev 1/2001 OCME 2006

State

Registrar

29b. Signature and title of certifier

Russell Alexander MD.

31. Date filed (Month, Day, Year)

AUG 0 2 201

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Registrar's Signature

29c. License number

O.C.M.E

900 W. Baltimore Street, Baltimore, MD 21223

29d. Date signed (Month, Day, Year)

July 27, 2011

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day LAVERNE JONES TULY 2011 10p Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner HOWARD GILCHRIST HOSPICE HOWARD COUNTY COLUMBIA If Under If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Year) 1 M 2 TF Months Hours Min 52 216-72-4542 Director MARYLAND -17-1959 Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location death with the Maryland Director 1X Yes 2 □ No BALTIMORE OWINGS MILLS MD. 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 29 GWINNSWOOD RD 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Was Deceuent 2... Armed Forces? 1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 😾 Married þ Baltimore, Maryland 21215-0036 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 🔽 No Specify. Specify: BLACK 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry College (1-4 or 5+) Elementary/Seconday (0-12) NURSE MEDICAL Page 1 and 2 should be filed wit nent of Health and Mental Hygie ant: If item 27 is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) EMMA JEAN WELLS JOSHUA GLOVER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. 29 GWINNSWOOD RD. OWINGS MILLS, MARYLAND 21117 RONALD JØNES SR. (HUSBAND) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) RIDGE CEMETERY 8-4-2011 BALTIMORE, MARYLAND of Fin eral Service License HIBNER 2. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, ear 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, bock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PLEURAL Ph_sician/ EFFUSION 15-MU-1, disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner CANCER METASTATIC Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Examine Cause (Disease or linjury that initiated events resulting in death) Last the burial-transi and Due to (or as a consequence of): physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) in the past 12 months? Year Month Day Pregnant at time of death signed by the aid be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ ACUTE RENAL FAILURE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Nown Completed 24b. Were autopsy findings available prior to completion of cause of death? HYPERTENSION 24a Was an page 2 s autopsy performed certificate 1 Yes 2 No Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 INPATIENT UNIT 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death filled in by the funeral Certificate: 28b. Time of Natural 28c. Injury at 28d. Describe how injury occurred After 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

within 24 hours after death.

To the Funeral Director: A

State Registrar

сотрые

only one)

29b. Signature and title of certifier

CEDAR

31. Date filed (Month, Day, Year)

LORIEN

a

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LKNE,

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

D0069962

MD 1

29d. Date signed (Month, Day, Year,

2011

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

COLUMBIA)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiener 24462 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JULY 30 2011 7:00 P M SOLIS JAMES Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death GILCHRIST HOSPICE CARE TOWSON BALTIMORE If Under 1 Year If Under 24 Hrs. Social Security Number **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 XM 2 □ F Months Days Hours Min. 0171271929 159-20-8413 Director 82 PA Usual Residence of Decedent 28a-f show 10a. State 10b. County must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Tes 2X No MD BALTIMORE BALTIMORE 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 3308 TIMBERFIELD LANE 21208 USA items 2 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces?,
1 Yes 2 No Black, White, etc. ò þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 72 hours after 1 Yes 2 XNo Specify: "natural", 3 Widowed 4 Divorced Completed Year or Dates WHITE Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) n 27 is marked other than "n traumatic event" (Give kind of work done during most of working life. DO NOT use retired) INFORMATION College (1-4 or 5+) 5+ Elementary/Seconday (0-12) TECHNOLOGY DIRECTOR TECHNOLOGY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be file tment of Health and Mental rtant: If item 27 is marked o ည CHARLES JAMES ELSIE GOLD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BERTHA JAMES/WIFE 3308 TIMBERFIELD LANE, BALTIMORE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once, 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) BETH EL MEMORIAL PARK 08/01/2011 RANDALLSTOWN, MD permit. Signature of Euheral San ce Loansee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD Part 1. Enter the disease, or complic shock, or heart failure. List only one or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final meer-metasta Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examiner if any leading to immedicause. Enter Underlying Due to for as windresconerow off To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, name 2 should be completed filled in by the funeral director, name 2 should be completed. Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: ves, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death Pregnant at time of death in the past 12 months?
1 ☐ Yes 2 ☐ No Month 1 Yes 2 L 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 52000, 2 No 3 Probably 4 Unknown Completed 1 Yes 24b. Were autopsy findings available 24a. Was an autopsy performed prior to completion of cause of death? 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 2 🗆 No ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at (Month, Day, Year) 1 Natural 5 Pending injury work Accident М 1 Yes 2 No Investigation 6 Could not be Suicide 3 ☐ Suiciae 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only on Certifying Norse Practioner: To the Seat of my knowledge ideath occurs d at the time date and place, and due to the

Registrar DHMH 17 Rev 7/2009

State

29b. Signature a

31. Date filed (Month, Day, Year)

AUG 0 2 2011

30. Name and address of person who completed cause of death (Item 28a) (Type, Print)

mo

Registrar's Signa

owo

29c. License number

N. Charles F.

25205

29d. Date signed (Month, Day, Year)

1	1-056	54	
Р	atrick	Kelly,	Sr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend # State of Maryland / Department of Health and Mental Hygiene

atrick (City, Or	1- For State Registrar Certificate of Death Reg. No.	4463
Physician/ Medical Examine	1) 1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year Odda	
medical Examine	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	
4.	30 Open Gate Court Nottingham Baltimore County	
Funeral Director	5. Social Security Number 218-64-3851 6. Sex 1218-64-3851 7. Age (In yrs. last birthday) 56 1218-64-3851 7. Age (In yrs. last birthday) 56 1218-64-3851 8. Date of Birth(MM/npgy55) 9. Birthplace (St. Months Days Hours Min. March 1, 1956 Foreign Country) MD	
in wany	MD Baltimore Nottingham	de City Limits
nore, MD 21215-0036 sges I and 2 should be filed within 72 hours after death with the Maryland att of Health and Mental Hygiene. att If item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 30 Open Gate Court 21236 USA	
or death with the office of the contract of th	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, White, etc.	
urs after of trural", or aminer m	3 Wildowed 4 Autorocad in tas, diversell or Dates: Specify: Will Co	
5-0036 led within 72 hour hygiene. other than "natu the Medical Exau Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 4yrs College (1-4 or 5+) Aerovautical Engineer FAA	
MD 21215-0036 d 2 should be filed within 7 d 2 should be filed within 7 in 27 is marked other than numaric event, the Medica To Be Comple	Thomas B. Kelly Sally A. Noonan	
MD 21 12 should th and Me 127 is ma umatic ev	 19a. Informant's Name/Relationship (Type, Print) Thomas Kelly /brother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1805 Sunnyside Lane Balto. MD 21221 	
Baltimore, MD 2 permit. Pages 1 and 2 shoul Department of Health and M Important: If item 27 is in injury or other traumatic.	20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition (Name of cemetery, crematory or other place) Oak Lawn Cemetery 8/2/11 Baltimore M	
Baltin permit. P Departme Importan injury or	21. Sonally of Funeral Surfice Licensee 22. Name and Address of Facility 300 MAce Ave. Balto. Connelly Funeral Home of Essex 21	
Physician /Medical	failure. List only one cause on each line.	mate Interval n Onset and Death
Examiner	or condition resulting in death) Due to (or as a consequence of):	
miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or injury that immaded	
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60, ate be exe hysician a e burial -	UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery	
Division of Vital Records, P.O. Box 68760, to the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completedy filled in by the funeral director, page 2 should be detached for use as the burial - transit edical Certification: To Be Completed by Physician/Medical Ex		Year
P.O. E es that the igned by the detached by the detached by the behavior of the detached by the behavior of th	Chronic alcohol use Circhosis of liver	of death?
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the stafer death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach entification: To Be Completed by P	24a. Was an autopsy finding autopsy prior to completion of death? 1 ✓ Yes 2 No 1 ✓ Yes 2	of cause of
tal Recion: Ti certifica	25. Was case referred to medical 26.Place of Death (Check only one)	
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Division of a tree Hospital or Attending Physicial or Attending Physicial or Attending Physicial About a theretal Director: After the completely filled in by the funeral Hodical Certification: T	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Nor Town, State)	umber, City
Divis To the Hospital or A within 24 hours after To the Foneral Dire completely filled in b		
	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Ye O.C.M.E. July 29, 2011	ar)
S.	30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	
State Registrar	e 31. Date filed (Month Day Year)	

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend items 23a-d, pt. II per doc g918 8-5-11 vt. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last, 2. Date of Death Physician/ 11:38 A M 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death K Baltimore 1405 Pita. ano **Funeral** 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Min. Months Days Hours 1 M 2 F (Month Day 9. CARTENA **Director** 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Exar iner must be notified at 10a State 10b. County death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director A ITIMORE 1 Yes 2 No Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. by 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give and 2 should be filed within 72 hours after 1 Yes 2 No 3 Widowed 4 Divorced Specify. Completed Year or Dates Decedent's Education 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. PO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Baltimore, Maryland 2121 Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh
Department of Health as
Important: If item 27 is
any injury or other trau 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) gemetery, crematory or other BANDA 115 TOWN N 21. Signatur uneral Service Licens 22. Name and Address of Facility A BAHI. MD. 2429 of the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest heart failure. List only one cause on each line. Apoxic Encephalonathy Approximate shock, or neart failu Immediate Cause (Final disease or condition resulting in death) Anoxic Encephalopathy Interval Between Onset and Death Emysician/ minutes Medical Due to (or as a cor Pulmonary Embolism Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last PNOXIC Due to (or as a consequence of): the attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? detached for Day Month Pregnant at time of death Year 9 🗌 Unknown 9 Unknown within 24 hours after death.

To the Funeral Director, After this certificate has been signed by completed filled in by the funeral director, page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Status Post Cardiac Arrest Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 2 🗌 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 V No မ Other: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work?
1 Yes 28d. Describe how injury occurred Natural injury 5 Pending 2 🗆 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Decrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) lan 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Certificate of Death Reg. N2 0 1 2 4 4 6 5											21.1.65					
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Physi Me	ician. edica	/		ard E.	,	r						July		Day 2011	Year	3. Time of Death 9:40 A M
Exar		4a.	Facility Name <i>(if not</i> 1119 Rosem			mber)				Location o				4c. Count	y of Deat	
Funer	ral		Social Security Numb			7. Age (In vrs.	last birthday)	If Under		If Under		8. Date of	Rirth	rion		hplace (State or Foreign
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29	(Check 2 I	vledical Exami	ner: On the bas	sis of examination	vledge, death o on and/or investi ny knowledge, d	igation, in m	y opinion,	, death oc	curred at the	he time, date	e and pla	ace, and du	e to the c	ause(s) and manner stated.
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Item 23a per dr.,g918,08/02/2011dbb
Certificate of Death
Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 1310 Maurice Robert Keys 201 Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Union Memorial Hospital Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 8. Date of Birth Jan 15, 1961 **Funeral** 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1 🛛 M 2 🗆 F **Director** Maryland 220-74-3449 50 Yrs Usual Residence of Decedent 28a-f show 10a. State 10b County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygene. In the Maryland Hygene. Start I filem 27 is marked other than "natural", or items 23a or 28a-f shour or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2 □ No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21218 1511 Carswell Avenue #1W USA 11. Marital Status unk 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify Specify: black Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation Unk (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Susie Martin Aaron Keys 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1521 Tunlaw Rd; Baltimore, MD 21218 Jean Johnson - sister Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Signature of Euneral Struck S. Wade, 22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Rhabdomyolysis Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence on Cause (Disease or linjury that initiated events burial-transi and Due to (or as a consequence of): resulting in death) Last nding physician are as the burial-Physician/Medical death certificate be Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery atten 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? detached for Month Pregnant at time of death Day Year Yes 2 No the 9 Unknown g Unknown been signed by t should be detach Part II. **Other** sig**nificant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed Yes 2 No certificate 1 ☐ Yes 2 ☐ No **Division of Vital** To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 🗌 Yes 2 🗹 No Other: ျ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director; After this completed filled in by the funeral directors. 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred 1 Natural 5 Pending injury ☐ Accident ☐ Suicide Investigation M

Registrar DHMH 17 Rev 7/2009

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only one 29b. Sig

31. Date filed (Month, Day, Year

29a Certifier (Check

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

n who completed cause of death (Item 23a) (Type, Print)

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Memoria

28f. Location (Street and Number or Rural Route Number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No . Decedent's Name (First, Middle, Last) 2 Date of Death Day Year 0340 AM -AWRENCE KMUFFMAN JULY 2011 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HOPKINS HUSPITAL THE JOHNS BALTIMORE CITY N/A 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 1 🛣M 2□ F Months Days Hours Min 156-32-9700 67 02/07/1944 PA Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location 1 Yes 2X No CAMDEN CHERRY HILL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 945 CHANTICLEER 08003 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 □ Yes 2 XNo If Yes, Give Year or Dates: Specify Specify: 3 Widowed 4 Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ PODIATRIST MEDICAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MORRIS KAUFFMAN SUE GORDON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) IRENE KAUFFMAN/WIFE 945 CHANTICLEER, CHERRY HILL, NJ 20b. Place of Disposition (Name of cometery, crematory or other place) CAMDEN COUNTY CREMATORY 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 07/31/2011 WATERFORD, NJ 21. Signature of Funeral Service Lice 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SEPSIS Due to (or as a consequence of): UDDENAL PERFORATION Sequentially list conditions Due to jor as a consequence of if any leading to immore cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last PANCREATIC CANCER Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗆 No 1 ☐ Yes 2 🗷 No 1 □Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred injury

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760. 24 hours after death.

Funeral Director: After this certific letely filled in by the funeral director.

Physician

/Medical

Examiner

Director

Funeral

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural" or items 23a or 28a-f show any highry or other traumatic event, the "hydical Eva". It it must be notified at appear.

Physician

/Medical

Examiner

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Physician/Medical

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Certification: To

Medical

State

Registrar

Baltimore, Maryland 21215-0036

25. Was case referred to medical examiner? 1⊠Yes 2 No 27. Manner of Death 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

21287

RESOOO

BALTIMORE

31 2011 JULY

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MICHOL COOPER

MARYLAND

NORTH 31. Date filed (Month, Day, Year)

WORFE STREET . Registrar's Signature

AUG O

DHMH 17 Rev 1/2001

within 24 ho

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68760 Box P.O. Records, Division of Vital after 24 hours

Baltimore, Maryland 21215-0036

28a. Date of injury (Month, Day, Year) Certificate: 1 🗶 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Acertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Q. holad Mes Doo 25010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SERGIA R. NOLAN MAD 8631 SATYR HILL 8831 SATYR HILLRO HIOD BACTIMORO, MD 21234 31. Date filed (Month, Day, Year) AUG 0 2 2. Registrar's Signature State Registrar

within 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 7:10P M Catherine Edith Long 07 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Franklin Sa Baltimore Roseda re Hospita Cente **Funeral** 8 Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 💢 F Months Min 12/20/1935 Director Mary Land 75 219-30-1375 Usual Residence of Decedent or 28a-f show 10a. State iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No Middle River Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 1216 Wilson Point Road 21220 U. S. A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ▼ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Low 9, Cother in C Baltimore, Maryland 21215-0036 \$ 1 Never Married 2 X Married 1 Yes 2 No Specify: "natural", Completed 3 Divorced 4 Divorced White Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n may injury or other traumatic event, the Media any. (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Assistant Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ernest William Mundy Catherine D. Rose 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1216 Wilson Point Road Middle River, Maryland Samuel Long, Jr. (Husband) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 872 2011 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 🕅 Other (Specify) Entombment Holly Hill Mem. Gard. Middle River, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Eastern Avenue PA Essex, Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ptic Shoc as a consequence of): Scotic disease or condition Medical resulting in death) Examiner Bowel Necros Sequentially list conditions, Examine Due to for as a consequence on ir any, leading to immediate cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or iinjury that initiated events the attending physician and resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birth 2 Live leta occ.
Pregnant at time of death in the past 12 months?
1 Yes 2 X No Month Dav Year 9 Unknown 9 Unknown cate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Director: After this certificate has autopsy performed Yes 2 No 1 Yes Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes Hospital 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident filled in by the Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours after To the Funeral Direct Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Li Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Li Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10 m 122364 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sarwate Dr. Devadatta MD, 9000 Franklin Square Drive, Baltimore MD,

Registrar

31. Date filed (Month, Day, Ye AUG 0 2 2011

Please amend
Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1tems 20a,22 per fh g918 8-2-11 vt.
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Physician 201 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore City The Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Jan 21, Birthplace (State or Foreign Country unk 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 X F 84 Director 217-20-1556 Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b. County 2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at 1 XYes 2 □ No Baltimore Director 10g. Citizen of What Country? 10f. Zip-Code 21224 10e. Street and Number 2113 Dundalk Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No white Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation unk (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry unit Elementary/Secondary (0-12) College (1-4 or 5+) unk unk traumatic event, 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked, any njury or other traumatic evenome. ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) unk19a. Informant's Name/Relationship (Type, Print) 2113 Dundalk Ave Baltimore MD 21224 Michael Reinfelder - son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 K Cremation 3 Removal from State Atlantic 7/22/2011 4 ☐ Donation 5 MOtho %) in Crem Glen Burnie MD state 21. Signature of Funeral Se , e .S.Thomas S. Wade Simplicity Cremation Director 7090 Ridge Rd Hanover, Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dy shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death such as cardiac or respiratory arrest, Immediate Cause (Final Physician disease or condition resulting in death) /Medical sequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a conseque re of) g physician and as the burial-transit requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 attending IF FEMALE: asn 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy for in the past 12 months? Month Day Year 5 Other (specify) d by the at detached f 1 Yes 2 No P.0. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I ģ of Vital Records, ate has been signe page 2 should be 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 🗌 Yes 2 No 1 🗌 Yes 2 🗌 No Physician: filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 | Inpatient Other: 2 NO 2 ER/Outpatient 3 DOA 4 \square Nursing Home 5 \square Residence 6 ☐ Other (Specify) 1 Yes မ this whith 24 hours after death.
To the Funeral Director: After this completely filled in twitter. 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural Division Injury 5 Pending investigation M 1 🗌 Yes 2 🗌 No Accident 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 17 per fh g918 8-3-11 vt
State of Maryland 7 Department of Health and Mental Hygiene

State Registrar Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death Physician/ July 20ÎÎ Milner 2:40 A M Josephine Bogart Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Harmony Hall Assisted Living Columbia Howard 5. Social Security Number Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** April 9 Months Hours Min. Days Ohio ⁷1911 Director 212-12-2222 100 Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked of other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or prother traumatic event, the Medical Examiner must be notified as Director 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 🗌 Yes 2 🔀 No Maryland Anne Arundel Pasadena 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1898 Cedar Road 21122 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🗷 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Completed 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Social Worker Baltimore City Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Allen Grant Bogart ပ Kissell Grant Bessie Lillian 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9745 Gudel Drive Ellicott City, Maryland 21042 Glenn L. Milner (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 08/03/2011 Baltimore, Maryland Dulaney Valley Mem 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 1,400 G land Ph, i i n disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death in the past 12 months? Month Day Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? HSSilv Hospital Other: ည 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After Natural 5 Pending М 1 Yes 2 No ☐ Accident Investigation the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 1 Certifying Physician to the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examples: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Narse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certific 2011 s of perse on completed cause of death (Item 23a) (Type, Print) 520 31. Date filed (Month, Day, Year) State Registrar

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Box 68760

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		-	For State Registrar			ertificate of			Reg. No.		24472
	Physicia	n/	1. Decedent's Name (First, Middle,	•				2. Date of I Month	Death	Year	3. Time of Death
	Medic Examin	al	Margaret Mitcl 4a. Facility Name (if not institution,			4b. City, Town,	or Location o		4c. C	County of Deat	
أمر	LAdmin		Good Samanita	n Hospita	d	Baltin		MD		NA	
	Funeral Director		5. Social Security Numberunk	5. Sex 1 □ M 2 🗓 F	73 Yrs.	Months Dav			Birth Day, 1933		thplace (State or Foreign
			219-32-8449 Usual Residence of Decedent		7.5						
	yland -f sho ied at	ctor	10a. State 10b. County		10c. City, Town or Baltin						10d. Inside City Limits 1 → Yes 2 □ No
	or 28a	Dire	10e. Street and Number			10f. Zip Code			10g. Citize	en of What Co	
	with t	Funeral Director	4700 Harford	Gardens		2121	4		US	SA	
396	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amportant: If item 27 is marked other than "natural", or items 53a or 28a-f show ampring yor other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 X If Yes, Give Year or Dates.	ver in U.S. 1	3. Was Decedent of If Yes, specify Cu		gin? (Specify Yes or N , Puerto Rican, etc.)		4. Race - Ame Black, White pecify: b1	
5-0	Phours Pratur dical I	plete	15. Decedent	's Education		cedent's Usual Occ ve kind of work don		of working	16b. Kin	d of Business	Industry
Maryland 21215-0036	ithin 72 ene. r than '	Completed	Elementary/Seconday (0-12)	College (1-4 or 5	i+) life	DO NOT use retire	d)		pı	rivate	homes
pq 5	filed w al Hygi d othe	Be	17. Father's Name (First, Middle, La				18. Mothe	er's Name (First, Midd	le. Maiden Su		
yla	uld be I Ment narke	욘	Mack Hardison				_	ie Mae Hai			
Mai	2 sho Ith and 27 is r traun	0	19a. Informant's Name/Relationshi Edward McClurkin					r or Rural Route Num altimore,			
re,	1 and of Hea f item		20a. Method of Disposition		20b. Place of Dis	sposition (Name of rematory or other p	lace)	Date	20c. Loc	ation - City or	Town, State
Baltimore,	. Page Iment tant: It		1 🔀 Burial 2 🗌 Cremation 4 🗌 Donation 5 🗆 Wother (St	ooiiiin state	let, Zi	on Cem		7-6-2011		to h	d. Titon C. Douglass
Bal	permit Depar Impor any in	J.	21. Signates of Fune al Service Li Ronald	Jy e, pix	ector	22 Name and Add	ress of Facility ice PA. I Baltin	701 McCillion	elst R	altimore	,MD,21217 ryland 21201
	Physician/ Medical Examiner	4	23a. Rart 1. Enter the disease, or or shock, or heart failure. List or immediate Cause (Final disease or condition resulting in death)	aly one cause on each line	the death. Do not of a consequence of).		ving, such as o	cardiac or respiratory	arrest,	31	Approximate Interval Between Onset and Death
		iner	Sequentially list conditions, if any, leading to immediate	b. —	a consequence of):						900
90	te be executed nysician and ne burial-transit	dical Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or as	a consequence of):						
Division of Vital Records, P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 burus after death. within 24 burus after death. To the Funeral Director. After this certificate has been signed by the attending physician To the Funeral Director. After this certificate bean signed by the funeral director, page 2 should be detached for use as the burial completed filled in by the funeral director, page 2 should be detached for use as the burial.	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant a g ☐ Unknown	2 Fetal death	3 ☐ Ectopic pregna 5 ☐ Other (specify)			_ 2	3d. Date of de Month	Blivery Day Year
P.0	that the	by Pt	Part II. Other significant condition	_				l. 23e. Di			o the cause of death?
rds,	equires een sig ould b	ted	Diabetes Typ	se 2, vem	swid , 14	recinitize					Probably 4 Unknown
00e	has by	Completed	anthritis					pe	itopsy erformed?	prior to death?	utopsy findings available completion of cause of
E E	in: The tificate or, pag	Be Co	25. Was case referred to medical			26.	Place of Deat	th (Check only one)	es 2) No	1 ∐ Ye	es 2 No
Vit	hysicia nis cer I direct	To B	examiner? 1 Yes 2 No		ent 2 🗆 ER/Outpa	tient 3 DOA	other:	ursing Home 5 🗆 R	esidence 6	Other (Spe	cify)
n of	ding P h. After ti funera	ate:	27. Manner of Death Natural 5 Pending		ry 28b. Time y, <i>Year</i>) injur	y w	jury at ork? □ Yes 2 □		e how injury	occurred	
Divisio	ial or Attenis after deat al Director:	Certificate:	2 ☐ Accident Investig 3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi	ot be 280 Place of Ini	ury - At home, farm, c. (Specify)			28f. Locatio	n (Street and Town, State)	Number or Ru	ural Route Number,
	ne Hospit n 24 hour ne Funera pleted fill	Medical	(Check 2 Medical Ex	Physician: To the best of caminer: On the basis of e Nurse Practioner: To the	xamination and/or in	vestigation, in my op	inion, death oc	ccurred at the time, da	te and place,	and due to the	cause(s) and manner stated
	To the within 2 To the comple		29b. Signature and title of certifier	,	M·D.		nse number		29d. Date	e signed (Mon	th, Day, Year)
			30. Name and address of person w	the completed correspond			,000		Jul	Y26	,3011
			1111 1 1 1			Altimare	· M· C	٠, ـ			
	Sta Registr		31. Date filed (Month, Day, Year)		ar's Signature	hares					

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amend Item 20c, per fh, g918 8-2-11 sm

All Indelibration of The Mark 20a - c, per fift, g918 6,8/4 /2014 ental Hygiene 2 0 | |

Certificate of Death

Reg. No. 24473 for State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 8:17 01 Medical 4a, Facility Name (if not institution, give street and number 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Johns HOPKINS 00 91+ Social Security Number 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F Days Months Hours Min. 214-82-6673 53 March 20, 1958 MaryTand Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland notified at Director Maryland Baltimore City 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö ed other than "natural", or items 23a or event, the Medical Examiner must be Funeral 4002 Erdman Ave. 21213 United States 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 V Never Married 2 Married ☐ Yes 2x No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 → No Specify: If Yes, Give Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Amusement Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Bud Metlow Delores Metlow 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rita D. Price/ 1000 Spa Road Apt. 103, Annapolis, Maryland 21403 20a. Method of Disposition

1 Disposition

1 Disposition

3 Disposition

3 Removal from State UKN: 20b. Place of Disposition (Name of cemetery, crematory or other place) Date UKN 20c. Location - City or Town, State Baltimore Lancdowne, MD Aug. 5, 2011 Western Cemetery 4 Donation 5 Other (Specify) 21. Signifure of Exp. ral Service Licensee Name and Address of Facility AMBROSE FUNERAL HOME OF LANSDOWNE MD. 2719 Hammonds Ferry Rd., Lansdowne MD. 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ ardiac disease or condition resulting in death) Medical Due to (or a va consequence of) **Examiner** Sequentially list conditions. Examine r any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events ng physician and as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for L in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) Yes 2 □ No signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performe death? within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical exampler?
1 ☑ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မြ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗖 only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person 4940 Eastern Avenue Balti 31. Date filed (Month, Day Year) State barke 2 Registrar 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 24474 Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month 10:30 AM 30 Jul 2011 Medical Eugene Joseph Moody 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Seasons Hospice at Northwest Hospital Baltimore Randallstown Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 🗆 F Days Hours Min. (Month, Day, Year)
Jan 15, 78 **Director** Jamaica 214-66-1702 Jan Usual Residence of Decedent show 10a. State 10b. County 10d. Inside City Limits ms 23a or 28a-f sho must be notified at 10c. City. Town or Location the Maryland Director 1 X Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral with United States 21215 3715 Columbus Dr items death \ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Examiner Armed Forces?

1 Yes 2 No Black, White, etc 0 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates "natural", 3 Widowed 4 Divorced Completed Black the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fis marked o permit. Page 1 and 2 should be.
Department of Health and Mental Important. If item 27 is many injury or other. ပ Unk Unk Unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Colin A. Moody /Son 1210 Park Glen Place Durham, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Durial 2 Cremation 3 Removal from State cemetery, crematory or other place) Aug 01 Beltsville, Maryland 4 Donation 5 Other (Specify) Chesapeake Crematory 2011 Signature of Funeral Service Lice 401585 22. Name and Address of Facility Cremation and Funeral Alternatives Kelesc 8717 Green Pastures Drive Towson 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ Celar 1ew disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month Year Pregnant at time of death 5 Other (specify) been signed by the should be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 €No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe page 2 After this certificate has 1 ☐ Yes 2 No • Hospital or Attending Physician: 24 hours after death. • Funeral Director: After this certific **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 \square Pending injury 1-Natural work? 1 ☐ Yes 2 ☐ No Accident Investigation completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the P within 2. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30,2011 031513 of death (Item 23a) (Type, Print) 30. Name and address of person who completed cause MO MO 2832 32. Registrar State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 24475 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Marcinkus July 30 Day 201 Pear Antanas 2:15P M Medical 4a. Facility Name (if not institution, give street and number)
Brooke Grove Nursi **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Nursing Home Olney Montgomery 5. Social Security Number 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) If Under 8. Date of Birth **Funeral** 8. Date of Birth (Month, Day, Year) 0/24/1924 Months Days Hours Min. 1 ★ M 2 □ F 86 Director Lithuanib Usual Residence of Decedent "natural", or items 23a or 28a-f shovedical Examiner must be notified at 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Directo Carroll Woodbine MD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21797 3101 Springhouse Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No If Yes, Give Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 ₩ Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Machinist Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Tekle Sovaiskaite Antana Marcinkus Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3101 Springhouse Court, Woodbine, MD Fabijus Marcinkus/Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Final Journey Crem. 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Termation 3 Removal from State 8/2/2011 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Doorta Marshall 22. Name and Address of Facility
Maryland Cremation Services PO Box 1413, Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ASPIRATION PNEUMONTA Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Completed by Be ဂ္ Certificate:

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 he Funeral Director: After wheleted filled in by the fun

	d	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1	23d. Date of delivery Month Day Year
	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
	ZT FAILURE, CORONARY ARTERY	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🌠 Unknown
DISEASE, P	ROSTATE CANCER	24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
25. Was case referred to medical examiner?	26. Place of Death (Chec	k only one)
examiner? 1 ☐ Yes 2 🗷 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 🔀 Nursing H	ome 5 Residence 6 Other (Specify)
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year) Injury work? on M 1 Yes 2 No	28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined	1 28a Place of Injury - At home form etreet factory office	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

33700

IED HOWE MD

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar DHMH 17 Rev 7/2009

within 24

Medical

29a. Certifier (Check

only one) 29b. Signature and title

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registra

NILLIAMSPORT

			For State of M	aryland /	Department of H Certificate of D		ental Hygie Re	ene g. N 2011	24476
	Physicia		1. Decedent's Name (First, Middle, Last) Jerry Ronald McGhee				2. Date of Death	30° 20°1°1	3. Time of Death 6:30a M
	Medic Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or		July	4c. County of Death)
	funeral			ge (In yrs. last birt	thday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	Balt:	onlace (State or Foreign
	Director		216-36-5918	72	Yrs. Worthis Days	Hours Willi.	Dec. 17	1938	Virginia
	aryland a-f shorified at	ector	MD Baltimore	10c. City, Town	n or Location dalk				10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	h the M 3a or 28 be noti	Funeral Director	10e. Street and Number 227 Robwood Road		10f, Zip Code 21222		10	g. Citizen of What Co	
	eath wit tems 2: er must	Funer	11. Marital Status 12. Was Decedent	Ever in U.S.	13. Was Decedent of His	panic Origin? (Spe	cify Yes or No-	USA 14. Race - Amer	ican Indian,
036	s after or ral", or i	by	1 ☐ Never Married 2 ☐ Married 3 ☑ Wildowed 4 ☐ Divorced Armed Forces 1 ☑ Yes 2 ☐ If Yes, Give Year or Dates.	No	If Yes, specify Cuban 1 ☐ Yes 2 ■ No		Rican, etc.)	Black, White Specify:	, _{etc.} Vhite
15-0	72 hour n "natul 1edical	Completed	15. Decedent's Education (Specify only highest grade completed)	1	a. Decedent's Usual Occupa (Give kind of work done du	iring most of worki	nσ	6b. Kind of Business I	•
212	d within lygiene. her tha	a l	Elementary/Seconday (0-12) College (1-4 or 9th	5+) R6	life. DO NOT use retired) epaired Med	dicalEqu	uipment	Neighbor	Care
<i>i</i> land	d be filed dental H irked ot tic ever	To B	17. Father's Name (First, Middle, Last) Charles McGhee			18. Mother's Name UN Kいの	e (First, Middle, Ma いいい	iden Surname)	
Man	12 shouk alth and N 27 is ma r trauma		19a. Informant's Name/Relationship (Type, Print) Robert McGhee /son		o. Mailing Address (Street ar 2923 Delawa				
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 □ Nourial 1 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	20b. Place of cemete.	of Disposition (Name of ery, crematory or other place Y HIII Ceme	tery 8/		Dc. Location - City or Baltimore	
Baltii	permit. P Departm Importar any injur once.		21. Signature of Funeral Service Licensee	<u>'</u>	22. Name and Address	of Facility 30	00 Mace	Ave. Bal	to. MD
			23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each lir	e.	not enter the mode of dying	, such as cardiac o	r respiratory arrest	ne of Ess	Approximate Interval Between
ā	Physician/ / Medical			d Stag	e Renal D	nsease	_		Onset and Death
	Examiner	er	Sequentially list conditions, b.						
di	outed nd ransit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events c	a consequence o					
Pap	ate be executed physician and the burial-transit	edical E	resulting in death) Last Due to (or as	a consequence of	of):				
68760	ertificate ding phy se as the	/Med	IF FEMALE: 23c. If yes, outcome	of pregnancy					
. Box 68	Attending Physician: The law requires that the death certificate be executed at death. sctor: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transity.	by Physician/M	in the past 12 months?		h 3 Ectopic pregnancy 5 Other (specify)			23d. Date of deli Month	very Day Year
Division of Vital Records, P.O.	requires that the de been signed by the should be detached	d by P	Part II. Other significant conditions contributing to death	ut not resulting i	in the underlying cause give	n in Part I.		cco use contribute to	the cause of death?
cord	law requ	Completed					24a. Was an autopsy	prior to c	opsy findings available ompletion of cause of
al Re	sician; The la certificate ha rector, page	Be Co	25. Was case referred to medical examiner?		26. Plac	ce of Death (Check		d? death? No 1 Yes	2 🗆 No
fVit	Physician; this certific ral director,	욘	Hospital:		utpatient 3 DOA Other	_4 □ Nursing Hor		ce 6 Other (Specif	iy)
o uo	ending eath. or: After he fune	Certificate:	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be		njury work?	es 2 🗆 No	28d. Describe how	injury occurred	
Divis	al or Att		4 Homicide determined 28e. Place of Injuilding, et	iry - At home, far c. (Specify)	rm, street, factory, office	2	28f. Location (Stree City or Town, S	et and Number or Rura State)	al Route Number,
_	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director. After this completed filled in by the funeral director.	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of only one) 3 Certifying Nurse Practioner: To the	xamination and/o	or investigation, in my opinion	. death occurred at	the time, date and r	place, and due to the ca	ause(s) and manner stated
	To th To th comp		29b. Signature and title of certifier		29c. License r			Date signed (Month,	
			30. Name and address of person who completed cause of c	eath (Item 23a) (Type, Print) Heavel	and Hos	pice	4 F. Rol	line:
	Stat	e_	CNSS FOODS (atonsmile 31. Date filed (Month, Day, Year) 37. Registr	ar's Signature	2/228 Sal	ome thai		(e, 50.	
	Registra		AUG 0 2 2011	J. J.	garle				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 17 per fh g918 8-18-11 yt
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ /lonth Mallie 32 a M Mae Montgomery Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death altimore Funeral 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🔽 F Months Days Hours Min (Month, Day, Year) 243-34-7404 Director 98 Usual Residence of Decedent "natural", or items 23a or 28a-f shov 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at with the Maryland Director 10d. Inside City Limits MD NA Baltimore 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2601 Madison Ave Apt 904 21217 U.S.A. death 1 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 ☐ Married Yes 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes Give Specify: Black Completed 3 Divorced Year or Dates other traumatic event, the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than " any injury or other traumatic event; the Mac any injury or other traumatic event; the Mac once. Elementary/Seconday (0-12) College (1-4 or 5+) 2th grade Care Domestic In Home Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Vinnie Hough Adolphus Corry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21117 Anderson Crenshaw-son 10090 Mill Run Circle, Owings Mills, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) 8/5/2011 Memorial 22. Name and Address of Facility
March F/H West Signatur of Juneral Service Licens Wabash 300 Ave, Baltimore, 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ port noion disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Kidhe. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Cause (Disease or linjury (andw myorath the burial-tran that initiated events resulting in death) Last signed by the attending physician and be detached for use as the burial-trar Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🛂 No Pregnant at time of death Month Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Wunknown been : . Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has page 2 autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? 1 Yes 2 🙀 No Other: ပ 1 🔀 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 1 Yes 2 🗌 No Accident 24 hours after death Funeral Director: Investigation completed filled in by the 3 Suicide
4 Homicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 To the F only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title o 29d. Date signed (Month, Day, Year) cause of death (Item 23a) (Type, Print) address of person who complet Janol 32. Registrar's State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 10:30 Year **Physician** Month Cecil George Mateer JULY 28 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death ORIEN-BELAIR HARFORD REL AIR if Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 9. Birthplace (State or Foreign Country) Ireland 5. Social Security Number Sex 1X M 2□ F 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Yea Funeral Director 229-36-2678 90 8, Aug. 1920 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar is ust be netitled at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Director Maryland Harford Forest Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2610 Hoopes Road 21050 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No þ Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced White Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Machinist Steel Manufacturer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William John Mateer Augnes Maud Duffy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sherrie Ruhl / Daughter 2610 Hoopes Road, Forest Hill, Maryland 21050 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 → Burial 2 Cremation 3 Removal from State Oak Grove Church Cem. 8-2-2011 4 ☐ Donation 5 ☐ Other (Specify) Bel Air, Maryland e of Fun ral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or coms that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death na ause on each line Immediate Cause (Final /hysician theumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause Entry (Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be execu Due to (or as a consequence of): P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death □Yes 2□No 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform Vital 1 □ Yes 2 🗆 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Division of Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death Funeral Director: 3 🗀 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier completely (Check only one) and manner stated within 2 To the the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MID , 1) 006398 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Harrede Grace MD 21078 Benjamin 669 Revolution M.D. 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Anna Maria Manq $\mathbf{J}_{\mathbf{u}}^{\mathrm{Month}}$ 29. 2011 9:15 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Forest Hill 2901 Kathleen Drive Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Germany Year) 9<u>28</u> Days Hours (Month, Day, Jan. Director 83 220-38-7274 Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🔀 No Forest Hill Maryland Harford 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 21050 2901 Kathleen Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black White, etc. 1 Never Married 2X Married þ If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify. Specify. Completed 3 Widowed 4 Divorced White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker 4 Own Home and Mental Hygie is marked other Be laryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anna (nmn) Freudelsberger Alfons (nmn) Bauer Page 1 and 2 should I 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 2901 Kathleen Drive, Forest Hill, Maryland 21050 Hubert Mang / Spouse timore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date emetery, crematory or other place, 1 Burial 2 X Cremation 3 Removal from State Towson, Maryland Hilltop Service Corp. 08-01-11 4 Denation 5 Other (Specify) 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 Part 1. Enter the disease, or composhock, or heart failure. List only ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. Approximate Interval Between Immediate Cause (Final Onset and Death -Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical 68760 as IF FEMALE: nse s 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown To the Hospital or Attending Physician: The law requires that the death Month Day Year Pregnant at time of death ate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 🗌 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner? Other: မ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 🗆 Nursing Home 5 Residence 6 Other (Specify) completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Tyes 2 🗌 No 24 hours after death Funeral Director: A Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \square Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and #tle signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 24480 State of Maryland / Department of Health and Mental Hygien For State Registrar Certificate of Death Reg. No 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2011 JULY 9:48A M Physician/ MILLER BARBARA ANN Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** FREDERICK FREDERICK FREDERICK MEMORIAL HOSPITAL 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) Social Security Number Feb. 3, Months Days Hours Min. Indiana **Funeral** °1941 1 🗆 M 2 🖾 F 70 316-42-3880 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 28a-f show 10b. County 10a, State "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director 1 ¥ Yes 2 ☐ No Frederick Frederick 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA Funeral 21701 2613 Bear Den Road Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? filed within 72 hours after death 11. Marital Status Black, White, etc. 2 🛭 No 1 Never Married 2 Married 1 Yes If Yes, Give White Completed by 1 Yes 2 X No Specify: Specify Baltimore, Maryland 21215-0036 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Ann Agnes Hudacin ၉ Steven Palikan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) MD 21638 124 Port Court, Grasonville, <u> Kelly Huber - Daughter</u> 20c. Location - City or Town, State 20b. Place of Disposition (Name of Metropolitan Crematory 20a. Method of Disposition 1 Burial 2 🔀 Cremation 3 🗆 Removal from State 7-28-2011 <u>Alexandria, VA</u> 4 ☐ Donation 5 ☐ Other (Specify) Burns Funeral Home & Crematory 22. Name and Address of Facility 21. Signature of Funeral Service Licensee once. 10101 Broadway, Crown Point, Indiana 46307 and 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death mediate Cause (Final 500 Vas Mala Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying to (or as a consequence of): Examine attending physician and for use as the burial-transit 101 or Attending Physician: The law requires that the death certificate be executed after death. Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 5 Other (specify) Pregnant at time of death signed by the a 9 Unknown 9 Unknowh 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a. Was an autopsy performed? Yes 2 No page 2 has Director: After this certificate 26. Place of Death (Check only one) 25. Was case referred to medical Division of Vital the funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 No 1 Nonpatient 2 ER/Outpatient 3 DOA 1 Yes မ 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death Certificate: 1 Natural 5 Pending М Accident
Suicide Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by Homicide ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. To the Hospital within 24 hours a Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and the to the cause(s) and manner stated.

Yes in the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed (Check only one 29d. Date signed (Month, Day, Year) 29c. License number offertifie 29b. Signature and

Registrar
DHMH 17 Rev 7/2009

State

300 West

St; Frederick

and address of person who completed cause of death (Item 23a) (Type, Print)

ry

MD

3. Re grar's Sala

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend State of Maryland & Department of Health and Mental Hygien 0 Certificate of Death Red No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 12:38A Edward Mackall Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death NA 203 N. Kenwood Avenue Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Director 213-54-5444 60 Usual Residence of Decedent 28a-f shov 10a, State 10c. City, Town or Location Important: If item 27 is marked other than "natural", or items 23a or 28a -f sho any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director MD 1X Yes 2 □ No NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 203 N. Kenwood Avenue 21224 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Black, White, etcAfrican Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. ģ 1 Never Married 2 Married Maryland 21215-0036 1 Yes XX No Specify: Specify: American Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Paul J. Rach and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Cement Finisher Construction 8th Grade NA Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Vernon Mackall Mary Morgan 19a. Informant's Name/Relationship (Type, Print) Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Theresa Mae Mackall 203 N. Kenwood Avenue Baltimore, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)

. Zion Cem. 1X Burial 2 Cremation 3 Removal from State Mt. 08-06-11 Lansdowne, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Wylie Funeral Home P.A. 22. Name and Address of Facility Street Baltimore, MD 21217 638 N. Gilmor 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Millie Physician/ disease or condition resulting in death) Medical Due to (or as a con equence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury and -tran that initiated events resulting in death) Last Due to (or as a consequence of): nding physician ause as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 use as yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Dav Year Pregnant at time of death Unknown 9 Unknown signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u></u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 has autopsy performed Yes 2 this certificate 2 **N**o 1 Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home 5 \(\overline{\Omega}\) Residence 6 \(\sum \) Other (Specify) 1 Tes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at After 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation within 24 hours after death

To the Funeral Director: /
completed filled in by the t 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one

Mackall

Edward

State

29b. Signature and title

30. Name and address of person who completed

eath (kem 23a) (Type, Print)

's Signature

32. Regis

29c. License number

940 EATTERN AVE BATTIMUM

29d. Date signed (Month, Day, Year)

			For State Registrar	State of	Maryland /		artment tificate			and M		giene Reg. No	Z U I	1	241	+82
	Physicia		1. Decedent's Name (First, Middle, I Brenda Lee Mey	,		_					2. Date of Demonstrated Month July		y 201	Year L	3. Time of 2240	Death M
	Medie Examir		4a. Facility Name (if not institution, g	ive street and numbe			4b. City, To			of Death	0 0 2 3	\neg	. County o	f Death		
	Funeral		Baltimore Washin 5. Social Security Number 6		cal Cente Age (In yrs. last bi	_	If Under 1	Year	ırnie If Under 2		8. Date of Birl	th		9. Birthr	unde1 olace (State o	r Foreian
	Director		218-36-6187	1 □ M 2 🔀 F	71	Yrs.	Months [Days	Hours	Min.	(Month, Da February	y, Year)	1940	Coun Mar	yland	
	nd how	٦	Usual Residence of Decedent 10a. State 10b. County		10c. City, Tov	vn or Loc	ation					***		1	0d. Inside Ci	ty Limits
	Aaryla 8a-f s tified	recto	Maryland Anne	Arunde1		Gam	brills								1 🗌 Yes	2 No
	a or 2 be no	al Di	10e. Street and Number			-	10f. Zip C	ode				10g. Ci	tizen of Wh	nat Cour	ntry?	
	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Funeral Director	917 Waugh Chapel			10.14	/ Dd		054	i-0 (0	:6 . Man and Na		ited			
9	er dea or ite miner	by Fu	11. Marital Status1 ☐ Never Married 2 ☐ Married		es?					, Puerto R	ify Yes or No- lican, etc.)		14. Race Black	White,	etc.	
Maryland 21215-0036	urs aff :ural", al Exa		3 ★ Widowed 4 □ Divorced	If Yes, Give Year or Date	s.	_ 1	☐ Yes 25	ζ ∐No	Specify:				Specify:	Whi	te	
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pu	2 should be filed within 72 in and Mental Hygiene. 77 is marked other than "traumatic event, the Med	To Be	17. Father's Name (First, Middle, Las	t)	•			- 1			(First, Middle,		Surname)			_
r <u>y</u> la	uld be d Men marke natic	-	Gilbert Montgom								Edwar					
	2 sho Ilth and 27 is r		19a. Informant's Name/Relationship Brenda Dawn Lewi				-				Route Numbe brills					
ore,	ge 1 and 2 should be filed within 72 hours after death with the Maryland tr of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	y i	20a. Method of Disposition		20b. Place	of Dispos	sition (Name	of	T	Da	ate		ocation - C			
Baltimore,	. Page tment tant: I jury o		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	ecify)	ate come	Cre	atory of othe Arund natory	·		ugus 2011					ryland	
Bal	permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra		21. Signature of Funeral Pervice Lice	ens e	M01386	22 D 14	Name and A onalds 411 An	Address Son napo	of Facility Fune 11s	ral H Road	lome & , Oden	Crem	nator Mary	y, F 71an	A. d 2111	3
	Ph _, sician/		23a. Part + Enter the disease, or of shock, of heart failure. List orly Immediate Cause (Final disease or condition	one cause on each	sed the death. Do line.							rest,			Approximat Interval Bet Onset and I	ween Death
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Division of Vital Records,	To the Hospital or Attending Physician: The Is within 24 hours after death. To the Funeral Director: After this certificate he completed filled in by the funeral director, page	Medical Certificate:	4 Homicide determine	28e. Place of	Injury - At home, fa etc. (Specify)	arm, stre	et, factory, o	ffice		2	8f. Location (S City or Tow	Street and In, State,	d Number	or Rural	Route Numb	per;
	Hosp 24 hol Fune eted fil	edic	(Check 2 Medical Exa	hysician: To the best miner: On the basis ourse Practioner: To	of examination and/	or investi	gation, in my	opinion,	death occ	curred at t	he time, date a	nd place	, and due t	o the car	use(s) and ma	nner stated
	To the within To the Comple		29b. Signature and title of certifier	urse Fractioner. 10	the best of my know	rieuge, u		icense ni	umber	and place	, and due to the		te signed (
) Leur) &	se, M.V),		D	RYC.	9/			7/3	1/6	201.	/	
	5		30. Name and address of person who		of death (Item 23a)	(Type, Pr	int)		7	0.00	. 6	,0	100	- M	2/	06/
	Stat	e e	31. Date filed (Month, Day, Year)	, Δ <i>U</i> ΣΤΣ 32. Regi	strar's Signature	001	TUSP	M	CD	KIVE	6LEA	JISU	RNI	2,11	4744	410
	Registra		AUG 0 2 2011	1	A 1											

	101	partment of Health and Mental Hy partificate of Death	giene Reg. No.2011 24483
Physician/	1. Decedent's Name (First, Middle, Last) Ruth Leona Miller	2. Date of De Month July	21, 2011 3. Time of Death 11:08 A M
Medical Examiner	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
	Anne Arundel Medical Center	Annapolis	Anne Arundel
Funeral Director	5. Social Security Number 6. Sex 1 \square M 2 \nearrow F 7. Age (In yrs. last birthday) 1 \square M 2 \nearrow F 90 Yrs.	If Under 1 Year If Under 24 Hrs. 8. Date of Bit Months Days Hours Min. (Month Days O 6 - 1 7 -	
and show dat	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Literature		10d. Inside City Limits
036 s after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at ed by Funeral Director	MD Anne Arundel	Severn	1 ☐ Yes 2 X No
a or 20 be not	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
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	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates. 15. Decedent's Education 16a. Dece	edent's Usual Occupation	Specify: White
21215-0036 within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho, the Medical Examiner must be notified at Completed by Funeral Director	(Specify only highest grade completed) (Give	e kind of work done during most of working DO NOT use retired)	16b. Kind of Business Industry
nd 212 lled within J. Hygiene. other tha rent, the A.	0	Disabled	Disabled
re, Maryland 21215-0 1 and 2 should be filed within 72 hour f Health and Mental Hygiene. Item 27 is marked other than "natuuther traumatic event, the Medical To Be Complete	17. Father's Name (First, Middle, Last) Oliver Miller	18. Mother's Name (First, Middle	, Maiden Surname) Unk .
Marylanc 2 should be flie Ith and Mental H 27 is marked o rtraumatic eve		ing Address (Street and Number or Rural Route Number	
e, M and 2 s Health Health ther trr	Mary Campbell / Caregiver 1724 20a. Method of Disposition 20b. Place of Disp	Severn Road Severn, Mar	
mor age 1 ent of 1 nt: If ith	1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State cemetery, cre	osition (Name of Date matory or other place) el Crematory 7-26-2011	20c. Location - City or Town, State
Baltimore, N permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr	777 222 0720	2 Name and Address of Facility Donaldson Funeral Home &	Odenton, Maryland
m gggga	REMILE IN CHICAGO	1411 Annapolis Road Oden	ton, Maryland 21113
Physician/	la. Par 1. Enter the disease, or complications that haus—the death. Do not en shock or heart failure. List only one cause on each line. Immediate Cause (Final	er the mode of dying, such as cardiac of respiratory at	rrest, Approximate Interval Between Onset and Death
Medical Examiner	disease or condition resulting in death) a. Due to (or as a bon at uence of):	Di Dallare	
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a ciar	resulting in death) Last Due to (or as a consequence of):		
Box 68760 death certificate be attending physical for use as the besician/Medic	d		
x 68 th certification of use a	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3		23d. Date of delivery
Bo he deat y the at ched for hysic	1 Ves 2 No 9 Unknown 4 Pregnant at time of death 5	Other (specify)	Month Day Year
Division of Vital Records, P.O. Box 6876 all or Attending Physician: The law requires that the death certificate is after death. In Director: After this certificate has been signed by the attending physician by the funeral director, page 2 should be detached for use as the Certificate: To Be Completed by Physician/Medi	Part II. Other significant conditions contributing to death but not resulting in the	, ,	tobacco use contribute to the cause of death?
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Division of To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t completed filled in by the funeral Medical Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office 28f. Location (Street and Number or Rural Route Number, wn, State)
Div To the Hospital or within 24 hours afte To the Funeral Div completed filled in I	29a. Certifier Certifying Physician: To the best of my knowledge, death	occured at the time, date and place, and due to the ci	ause(s) and manner as stated.
the Hospita in 24 hours the Funeral pleted filled	(Check 2 ☐ Medical Examiner: On the basis of examination and/or inversionly one) 3 ☐ Certifying Nurse Practioner: To the best of my knowledge,	stigation, in my opinion, death occurred at the time, date	and place, and due to the cause(s) and manner stated.
To 1 To 1	29b. Signature and title of certifier	29c, License number 3681	29d. Date signed (Month, Day, Year)
	30. Name and address of person who completed cause of death (Item 23a) (Type,		1/4 / / / /
·	Ajit Kurup, M.D. 900 Van Buren Stre	et Annapolis, Maryland 21	403
State Registrar	31. Day Gloc (Month, Day Year) 32. Registra's Signature	,	

osnua Medott		State of Maryland / 1- For State Registrar		ificate of		ı Mentai	Hygiene	Reg. No.	201	24484
Physicia ledical Exami		1. Decedent's Name (First, Middle,Last) Joshua Aaron Medoff					2. Date of D Month July 28,	Day	Year	3. Time of Death 0623 hrs
		Fecility Name (if not institution, give street and number) Union Memorial Hospital		4	b. City, Town, or I Baltimore	ocation of D	eath	4c.	County of Deat	h
Funeral Director		5. Social Security Number 6. Sex 7. Age 218-96-3936 1 M 2 F	e (In yrs. las	st birthday)	If Under 1 Year Months Days		Min	Birth (MM/I	Forei	thplace (State or grand) Puntry)Maryland
any		Usual Residence of Decedent 10a. State 10b. County	10c. City, T	own or Location	on					10d. Inside City Limits
Aaryland 28a-f show 1 at once.	jo	MD Howard	Со	lumbia						1 X Yes 2 No
th the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number	11.20		10f. Zip Code	_			en of What Cou	ntry?
with th ns 23a be noti		5255 W. Running Brook Road 11. Marital Status 12. Was Decedent I		. 13. Was	21044 Decedent of Hisp					ican Indian, Black,
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 3 Widowed 4 Divorced If Yes, Give Year	X No		es, specify Cuban, Yes $2[\overline{X}]$ No		erto Rican, etc.)		White, etc. Specify:	White
iours afi natural'	ed by	15. Decedent's Education (Specify only highest grade com	pleted)	16a. Decedent	's Usual Occupation	on (Give kind			ind of Business/	
136 hin 72 h e. than "r	Completed	Elementary/Secondary (0-12) College (1-4 or 5	+)		e Managei		remedy		Public	Health
5-00 lied wit Hygien other		17. Father's Name (First, Middle, Last)		Case	-	8.Mother's N	ame (First, Middle	e, Maiden S		negren
21215-0036 nuld be filed within 7 Mental Hygiene. marked other than c event, the Medica	To Be	Lawrence Peter Medoff 19a. Informant's Name/Relationship (Type, Print)		19b. Mailing	Address (Street	Peggy	Johns		ty or Town. State	z. Zip Code)
MD id 2 sho lith and m 27 is sumati	- 9	Lawrence Medoff / Father	- 11	5255 V	W. Runnin	ng Bro	ok Rd, #	301,	Columbi	a, MD 21044
lore, ges lar t of Hez : Hitel		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State		ace of Dispositematory or other	ion (Name of cem er place)		Date		ocation - City or	
Baltimore, permit. Pages 1 ar Department of Her Important: If ite injury or other tr		4 X Donation 5 Other Specify: 21. Signature of Funeral Section 1 is unsee	Anat	COTY Gift 22. Na	ts Registr ame and Address		8/01/201 Anatomy			Maryland rv
		23a. Part I. Enter the disease or complications that caused t	be death F	752	22 Conne	lley D	r., Ste.	P, F	Hanover,	MD 21076
Physician /M i	1	failure. List only one cause on each line. Immediate Cause (Final disease a. <u>Diphenhyd</u>)				uch as cardia	ic or respiratory a	arrest, sno	ck, or neart	Approximate Interval Between Onset and Death
Examiner		or condition resulting in death) Due to (or as a consect		s Incox	CICACION					
	je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	quence of):							
d sit	Examiner	(Disease or injury that initiated events resulting in death) Last	quence of):							
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transi	Medical	x UNPENDED AMENDED 23a,	27,28	a-f,pe	r me,g918	8 8-4-	ll sm			
760, ficate be ex g physician the burial	/Wed	IF FEMALE: 23c. If yes, outcome 23b. Was decedent pregnant in the	e of pregna			7e			. Date of deliver	
Box 6876 death certificate the attending phy defor use as the	Physician/N	past 12 months?	ime of deat		al death 3 _ er (S <i>pecify)</i>	Ectopic pre	gnancy		Month [Day Year
O. BC at the der		Part II. Other significant conditions contributing to death	but not resi	ulting in the un	iderlying cause giv	ven in Part I.	23e. Did	I tobacco u	se contribute to	the cause of death?
S, P.O uires that t n signed by	ed by									pably 4 🗹 Unknown
of Vital Records, ag Physician: The law require the certificate has been sineral director, page 2 should be	Completed				-			is an opsy form <u>ed</u> ?		topsy findings available completion of cause of
		25. Was case referred to medical			26.Place o	of Death (Che	1 ✓ Yes	2 No		es 2 No
n of Vital ading Physician: th. : After this certifi f funeral director,	To Be	examiner? 1 Ves 2 No Hospital: 1 Inpatien		R/Outpatient			rsing Home 5			
	Ë	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day,Yei	ar)	8b. Time of Inj $(d\ 12:1)$		atWork? es 2. <mark>K.</mark> No	28d. Describ	- 1	ry occurred gested	drug
Vis or At fler d Direct in by	Certification:	2 Accident Investigation	ıry - At hom		, factory, office bu		28f. Location or Town, Baltim	(Street an State)32 ore M	d Number or Ru 22 West 3	ral Route Number, City 0th St.
Divis To the Hospital or Avithin 24 hours after of To the Funeral Direct completely filled in by	Medical C	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of exam and manner stated.					and due to the ca	use(s) and	I manner as state	ed.
FSFÖ	Ž	29b. Signature and title of certifier	. 4		29c. License		-		ate signed (Mo	nth, Day,Year)
	-	30. Name and address of person who completed cause of de	ath (Item 23	3a)	O.C.M	,E.		July	29, 2011 	
		Carol Allan, MD Assistant Medical Exam	iner 90	00 W. Baltir	more Street, E	Baltimore,	MD 21223			
Sta	ate	31. Date filed (Month, Day, Year) 32. Registrar's								

DHMH 17 Rev 1/2001

OCME

ORIGINAL

ames Odom		State of Maryland / Department of Health and Mental H		2011	24485
Physicia Medical Examir	ın/	1. Decedent's Name (First, Middle,Last)	2. Date of Death	Day Year	3. Time of Death 1720 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Dea 5219 Wilton Heights Baltimore		4c. County of Deat	h
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 Months Days Hours Mi		Forei	rthplace (State or gn
Maryland 28a-f show any d at once.	or	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10c. City Town or Loca			10d. Inside City Limits 1 7es 2 No
death with the Maryland or items 23a nr 28a-f sho must be notified at once	ral Director	10e. Street and Number 5219 Wiltow Heights Ave. 2/2/5 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (3		g. Citizen of What Cou	intry?
	by Funeral	Armed Forces? Yes 2 No No specify:	o Rican, etc.)	White, etc.	ack
vithin 7: ene. er than	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) Long Shorema	etired)	Beth Steel	chan
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be	James Odom Se Adl	neB	aiden Surname)	
2 2 2 2 2	2	19a. Informant's Name/Relationship (Type, Pri/lit Daughka) 19b. Mailing Address (Street and Number of Matietta P Gambi 13845 Find 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Rural Route Numb	0 11	ND 2/2/3
Baltimore, permit. Pages l a Department of He Important: If ite		1 Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Fapility	5/2011	OWINGS M	ITE MD
M 링스트를 Physician	4	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac	Booke	MA 2/2/	Approximate Interval
/Medical xaminer		failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular Disease complicated by Hyperocondition resulting in death) Due to (or as a consequence of):			Between Onset and Death
	miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause b			
executed an and al- transit	Ž	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.			
be exestician sician aurial -	edical	UNPENDED AMENDED			
Division of Vital Records, P.O. Box 68760, The the Hospital ar Attending Physician: The law requires that the death certificate be execut within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregr 4 Pregnant at time of death 5 Other (Specify) 9 Unknown	ancy	23d. Date of deliver Month	y Day Year
res that the d signed by the	إھ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes mellitus, Morbid obesity		pacco use contribute to	
Division of Vital Records, Ital in Attending Physician: The law requires is after death. al Director: After this certificate has been signed in by the funeral director, page 2 should be	Completed		24a. Was ar autops perform	n 24b. Were at y prior to ned? death?	utopsy findings available completion of cause of
Vital Rec ysician: The his certificate director, page	ပို Be	25. Was case referred to medical examiner?	1 Yes 2	No 1 ✓ Y	es 2 No
Physic Physic er this c	의			Residence 6 Othe	r: Scene
Sion of Attending Physical death. ctmr: After 1 y the funeral	ation	1 Natural 5 Pending Pending Investigation P		sed to environme	ental heat
Divisior To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Could not be determined (Specify) Townhouse / Rowhouse	or Town, Sta 5219 Wilton He	ate) eights, Baltimore, M	
Tn the Hos within 24 h To the Fun	edica	(Check only one) 2 Medical Examiner: On the bast of my knowledge, death occurred at the time, date and place, an examination and/or investigation, in my opinion, death occurred and manner stated.	d due to the cause at the time, date ar	r(s) and manner as stated and place, and due to the	red. ne cause(s)
		29b. Signature and title of certifier O.C.M.E.		29d. Date signed <i>(Mo</i>	nth, Day, Year)
0	ł	 Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street, Balti 	more, MD 212	223	
Sta Registr	te	31. Date filed (Month, Day, Year) AUG 0 2011 32 Registrar's Signature			

OCME

Alfred Stewart O		1- For State Registrar	ate of Maryla		artment o		nd Mental		Reg. No.		24486
Physicia Medical Examir		Decedent's Name (First, Middle ALFRED	STEWART		ОСКО)		2. Date of D Month July 26,	Day Yea		3. Time of Death 1117 hrs
		4a. Facility Name (if not institution, 102 Charles Court		nber)		4b. City, Town, o			4c. County	of Death	
Funeral Director		111-22-0067	6. Sex 7	7. Age (In yrs. I	last birthday) 80 Yrs	If Under 1 Ye Months Da		Min.	Birth(MM/DD/YYYY	Foreign	
м ану		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Locat	ion					10d. Inside City Limits
Maryland 28a-f show d at once.	ector	MD CE 10e. Street and Number	ECIL_	NO	ORTH EAS	T 10f. Zip Code			10g. Citizen of Wh	hat Count	1 Yes 2 No
h with the h ms 23a or be notified	Funeral Director	102 CHARLES CO	12. Was Dece				lispanic Origin?	(Specify Yes or I			USA can Indian, Black,
nore, MD 21215-0036 sges I and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. tt If them 27 is marked other than "natural", or items 23s or 28s-f sho other traumatic event, the Medical Examiner must be notified at once.	2		1 A Yes	2 No	1	Yes 2 X N	o specify:	uerto Rican, etc.)	Specify:	e, etc. WHIT	
136 hin 72 hour e. than "natu tedical Exan	Completed	15. Decedent's Education (Specific Elementary/Secondary (0-12)	College (1-4	4 or 5+)		nt's Usual Occupa	e. DO NOT use		16b. Kind of Bu		
MD 21215-0036 of 2 should be filed within 7 lith and Mental Hygiene. m 27 is marked other than aumatic event, the Medica	Be Com	17. Father's Name (First, Middle, L	.ast)	_4	ОСКО	PHIS	ICIST 18.Mother's N IDA	ame (First, Middle	e, Maiden Surname	•	NCE EBSKY
WD 21; 12 should the and Men 127 is mar umaric cva		19a. Informant's Name/Relationshi	ip (Type, Print) SISTER		19b. Mailing		et and Number		NYSIDE, N	m, State, 2	Zip Code)
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Baltii permit. Departm Imports		21. Signeture of Funerat Service	CHY.	IN	22. N	lame and Addres	ss of Facility S	OL LEVIN	SON & BRO	OS.,	INC.
Physician M d Examiner	1	23a. Part I. Enter the disease, or or failure. List only one cause or Immediate Cause (Final disease or condition resulting in death)		ic Stenosis	n. Do not enter the complicated	he mode of dying	g, such as cardia	ac or respiratory a	arrest, shock, or hea	art	Approximate Interval Between Onset and Death
		Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause	b. Due to (or as a co							\dashv	
executed an and al - transit	Exam	(Disease or injury that initiated events resulting in death) Last	Due to (or as a co	onsequence of	rf):						
L Sici	edicai	UNPENDED	AMENDED								
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P.O. Be st that the digned by the be detached	<u>a</u>	Part II. Other significant condition	ns contributing to d	leath but not re	esulting in the u	nderlying cause	given in Part I.		tobacco use contrit es 2 ✓ No 3		ne cause of death?
Division of Vital Records, P.O. Ital or Attending Physician: The law requires that the stater death. In Director: After this certificate has been signed by lied in by the funeral director, page 2 should be detacted.	Completed							perf	opsy proformed? de		opsy findings available impletion of cause of
Vital Recyrician: The his certificate director, page	8	25. Was case referred to medical examiner?	Hospital: 1 Inc	patient 2	ER/Outpatient		e of Death (Che	· · · ·	Residence 6		
on of V ending Phy ath. or: After th	tion:	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date of FOUND:	Injury Day, Year)	28b. Time of In	njury 28c. Inju	ury at Work? Yes 2 ✓ No	28d. Describe	e how injury occurre ayed in heat		5CB1 IB
Division of To the Hospital or Attending Physiphin 24 hours after death. To the Funeral Director: After to the Funeral Director: After to the Completely filled in by the funeral Completely filled in by the funeral completely filled in by the fun	Certification:	2 Accident Investig 3 Suicide 6 Could r 4 Homicide	not be 28e. Place of			et, factory, office b	building, etc.		(Street and Numbe State) Court, North Eas		al Route Number, City
Fo the Host vithin 24 ho Fo the Fund completely f	ल	29a. Certifier 1 Certifying Physical Cone) 2 Medical Examination	sician: To the best o iner:On the basis of e and manner state	examination ar	ge, death occurr nd/or investigati	red at the time, dation, in my opinior	ate and place, and pla	and due to the cau ed at the time, dat	use(s) and manner e and place, and du	as stated ue to the	l. cause(s)
	W Z	29b Signature and title of certifier	the De	2/12	000	29c. Licens O.C.			29d. Date signe July 27, 201		n, Day, Year)
0	3	30. Name and address of person while Victor Weedn MD JD	ho completed cause Assistant Medi	•		. Baltimore S	Street, Baltir	more, MD 212	223		
Sta Registr		31. Date filed (Month, Day, Year) AUG 0 2 20	37 Regi:	strar's Signatu	· for	4					

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Name (First, Middle, Last) 2. Date of Death Physician/ Month 10:40 am Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Genesis Eldercare Severna Park Severna Park 9. Birthplace (State or Foreign Country) **Ohio** If Under 1 Year If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days OCT. 10°-21916 Months 1 🗆 M 2 😿 94 301-24-3005 Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 X No Anne Arundel Severna Park Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Funeral 23a 21146 United States 24 Truck House Road or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces' Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: White "natural", Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) Department of Health and Nental Hygen Important: If item 27 is marked other than any injury or other traumation. NSA Office Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Laura Longworth Wilbur Hutchinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Kay Bennett / Daughter 571 Manor Road, Severna Park, Maryland 21146 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 08/01/2011 Baltimore, Maryland 22. Name and Address of Facility Cremation Society of Maryland 21. Signature of Funeral Service Licensee Alyson K Taylor 299 Frederick Rd., Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ weeks resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Lause (Disease or injury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 movins?
1 Yes 2 No Month Day Pregnant at time of death 1 ☐ Yes ∠ E g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? covonalu 2 No 3 Probably 4 Onknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsv perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation Director Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

State Registrar 31. Date filed (Month, Day, Year)

terars Hwy Millersville MD 2NO8

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Bethany Month Dav Year Phelps 6'. 20 P M JULY Medical 2011 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Seasons Hospice at NW Hospital Randallstown Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🗡 F Hours (Month Day Year) 218-98-0613 44 Maryland **Director** 1967 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Director Baltimore 1 Tes 2 No MD Nottingham 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1 Highhaven Place Apt. T-C 21236 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Never Married 2 ☐ Married Black White etc. <u>ک</u> ould be filed within 72 hours after of Mental Hygiene. marked other than "natural", or 1 Yes : 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Divorced Specify White Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important. If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Waitress Hospitality Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Robert A. Phelps, Jr. Marcia A. Riggin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shari Tweed /Sister 1645 Curlett Drive Dayton, OH 45432 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Aug 01 1 🗆 Burial 2 🕱 Cremation 3 🗆 Removal from State cemetery, crematory or other place, Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 2011 21. Signature of Funeral Service Licensee 22. Nationatives of Family Funeral Alternatives Kelbecco Hac 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph. sician/ ovarian cancer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events and-tran Due to (or as a consequence of) nding physician ause as the burial-t resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Pregnant at time of death Day Year 2 No g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 🗹 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a Was an prior to completion of cause of death? performed Yes 2 2 🗌 No 1 Tyes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ns Rajapaha M.O

DHMH 17 Rev 7/2009

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2835 Smith

Rajapakse, M.D

DO057465

5-203

Baltimore

MD

21209

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Pannell Physician/ Month Day Elizabeth 7011 0530 M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Scaggsville Road Howard Laure: 7 Age (In vrs. last hirthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛛 F Days 0871471951 Director 541-60-4469 Nevada 59 Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Howard Laurel ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? should be filed within 72 hours after death with the and Mental Hygiene.

is marked other than "natural", or items 23a or is marked other than "natural", or items 23a or is marked other than "natural", or items 23a or is marked other than "natural", or items 23a or is marked other than "natural", or items 23a or is marked other than "natural", or items 23a or is marked other than "natural", or items 23a o Funeral 11111 Scaggsville Road 20723 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 Married þ 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 🗌 Widowed 4 🗆 Divorced Specify: Completed Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Robert Grady Pannell Anne Allen Birdwell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau once. Robert Pannell / Brother 12723 Lode Street, Bowie, MD 20720 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) Anatomy Gifts Registry 08/01/2011 | Hanover, Maryland 21. Signatur of Funeral S vice Licens e 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ anchentic Canca disease or condition JOAN Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Disease or impury that initiated events Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed -tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 attending physical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 2 **1**No 4 ☐ Pregnant : 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ♣No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes ျ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ♣ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred H Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral D 1-🖼 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Contributing Nurse Prantioners To the best of my knowledge, death occurred at the time, data and place, and due to 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 31, 2011 **D**37573 30. Name and address of person who cause of death (Item 23a) (Type, Print)

Registrar

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32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 24490 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Jacqueline July Marshall 30, 2011 11:24 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Baltimore Greater Baltimore Medical Center Towson 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 ▼ F 212.84.0627 Hours Min. Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at one. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Baltimore MD heisterstown 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral USA Bonmot Place Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc 1 Never Married 2 Married Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: If Yes, Give Year or Dates Black Specify: 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) State of Maryland 12tharade wedianal vears Be 17. Father's Name First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ *Marlas* Callie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bannot Place iressa M. McQueen/Daughlet MD 21136 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State PikesvIIIe, MD Dried Ridge Cemeton 106 2011 08 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee C. Greene Puneral Services 22. Tame and Address of Cility Vaughn Randalistown MD 21133 Road 23a. Part 1. Enrich the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart filture. List only one cause on each line. Approximate Interval Between Immediate Cau, e (Fin II disease or con Hion resulting in death) Onset and Death Physiciam/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or iinjury the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-trai Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Dav Year Pregnant at time of death After this certificate has been signed by the funeral director, page 2 should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 Yes 25. Was case referred to medical examiner?

1 Yes 2 No Be (26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 1 Natural 5 Pending work? 2 🗆 No Accident Investigation within 24 hours after death

To the Funeral Director: / 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00043489

Registrar
DHMH 17 Rev 7/2009

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32. Registrar's Signature

N. Charles St.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 24491 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 2011 7:20 A M Catherine Scott Patterson Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's Prince George's Hospital Hvattsville 5. Social Security Number Year If Under 24 Hrs 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 🔀 F Months Hours Min OCT 5, 1949 Washington DC Director 218-56-3934 61 Usual Residence of Decedent or 28a-f show notified at filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Prince George's Colmar Manor ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Examiner must be Funeral 23a 4013 Newton Street 20722 United States items ? 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. ō þ 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Completed 3 Divorced 4 Divorced White Year or Dates Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 2 should be filed where the and Mental Hygiene.

"And other than "r".

"And other than "r". (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Accountant Government permit. Page 1 and 2 should be filed wi Department of Health and Mental Hygir Important: If item 27 is marked other any injury or other traumatic event, I Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Thomas Weston Scott, Jr. Agnes McGee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3701 41st Ave. Cottage City, MD 20722 Shane M. Fuegel / Son Important: If iten any injury or othe 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Journey Crematory 8/2/2011 Woodbine, Maryland Signatu Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, M MD 21029 MO1251 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Multidisease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sta Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit signed by the attending physician and dbe detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE; Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☒ No Month Year Day Pregnant at time of death Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> Completed 1 Yes 2 No 3 Probably 4 Unknown peen s 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? death? this certificate Yes 2 X No 1 🗌 Yes Hospital or Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No ၉ 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA completed filled in by the funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes After t 28d. Describe how injury occurred 1 X Natural injury 5 Pending 2 No Accident Investigation 24 hours after deat Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b, Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License numbe D7109 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Samreey

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. R

State of Maryland / Department of Health and Mental Hygiene For State Registrar 24492 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 29 Day y 2011 JULY Month 11:03 AM <u>JOSEPH A. PAPIRI</u> Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 8126 OAKLEIGH ROAD BALTIMORE PARKVILLE Social Security Number **Funeral** 7. Age (In yrs, last birthday 8. Date of Birth 9. Birthplace (State or Foreign 1 🛛 M 2 🗆 F 84 Hours (Month, Day, Year) 12/29/1926 Director MARYLAND 212-20-4147 Usual Residence of Decedent 11.03 gm show at 10a. State 10b. County 10c. City, Town or Location with the Maryland Director 10d. Inside City Limits or 28a-f sh notified 1 Yes 2 XNo BALTIMORE MD PARKVILLE 23a or 3 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Examiner must be Funeral 8126 OAKLEIGH ROAD 21234 USA items ? 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 X Yes 2 If Yes, Give Year or Dates. ō þ 1 Never Married 2 X Married 2 No after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", 3 Widowed 4 Divorced WWII Specify: Completed WHITE 27 is marked other than "natu traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life, DO NOT use retired) during most of working BALTIMORE CITY WATER Elementary/Seconday (0-12) College (1-4 or 5+) 12TH GRADE SUPERINTENDENT DEPT. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked of မ VINCENT PAPIRI JOSEPHINE CONSTANTINO 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other to once. 8126 OAKLEIGH ROAD NORMA R. PAPIRI/WIFE PARKVILLE. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) PARKWOOD CEMETERY 8/1/2011 BALTIMORE, MD THE JOHNSON FUNERAL HOME, P.A. Funeral Service Lice 22. Name and Address of Facility MO1139 8521 LOCH RAVEN BLVD. TOWSON. MD Part 1. Enter the disease, or compleations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final CONGESTINE HEART FAILURE Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician a be detached for use as the burial-Physician/Medical 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregnancy
5 Other (specify) Live Birth 2 - Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day g Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Records, 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 No 욘 1 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 2 Inpa 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural injury 5 Pending work 1 Yes 2 No Accident Investigation M 6 Could not be Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and tij (Month, Day, Year) person who completed cause of death (Item 23a) (Type, Print) 300 State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Phillips Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Wicomico Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 M 2 X Months Hours Min. July 24, Director 212-07-7595 95 1916 Maryland Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Baltimore Sparrows Point Maryland 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9026 Avenue B 21219 USA permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 XWidowed 4 Divorced White Mercy 1 v 2215-1 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 6 years **HOusewife** Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Stephen Arthur Rosa Rossmark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9026 Avenue B, Sparrows Point, Maryland Alma Kendall Daughter Baltimore, injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or ot once. 20c. Location - City or Town, State August 1, 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Bayview Crematory Baltimore, Maryland 21. Signature of Funeral Service Licer Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. per the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ ASCVD disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery Live Birth 2 Fetal death in the past 12 months? Month Year Day Pregnant at time of death cate has been signed by the a page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No After this certificate ☐ Yes the Hospital or Attending Physician; on 24 hours after death, the Funeral Director: After this certified the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital No No Other: မှ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Sther (Specify) Ho 4 Nursing Home 5 Residence 6 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred lake 1 Natural injury 5 Pendina work? M 1 Yes 2 🗌 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide within 24 hours after de To the Funeral Directo completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 713012011 0 63199 30. Name and add ss of person who completed cause of death (Item 23a) (Type, Print) SHORE DR., SALISBURY. VO HRA YOGES 910 ENSTERN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 0 2 201 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 24494 For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year Medical 201 4a. Facility Name (if not institution, give street and number) Examiner Town, or Location of Death 4c. County of Death len Arm Baltimore 402 lane Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 F Days Months 217-26-1796 Hours Juneth, 19 797928 Maryland 83 **Director** Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at 10b. Count 10a, State 10c. City, Town or Location 10d. Inside City Limits Director Baltimore County Glen Arm Maryland 1 🗆 Yes 2 🗗 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21057 Funeral 4402 Dulaney Court United States 12. Was Decedent Ever in U.S. Armed Forces 2, 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. à 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural", 3 Widowed 4 Divorced White Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 l
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ns
any injury or other traumatic event" ... (Specify only highest grade completed) College (1-4 or 5+) N/A Elementary/Seconday (0-12) Home Maker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Kathryn Rosendorne John Lester Mintiens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4402 Dulaney Court Glen Arm, Maryland 21057 Mr. William Edward Riley(Husband) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location 1 City or Town State (Baltimore County) Wednesday, Aug.03,2011 1 Burial 2 ☐ Cremation 3 ☐ Removal from State remetery, cremetory or other place Ĉh. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligensed Effrey L. Gair, Sr. FSP Name and Address of Facility Peaceful Afternatives Funeral and Cremation Center P.A. 2325 York Road Timonium, Maryland 21093-2215 an Aic. #100677 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between MYELOMA Immediate Cause (Final MULTIPLE Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): 5 MONTHS Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 the Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No for Day Pregnant at time of death Month Year n signed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas performed? Yes 2 X No After this certificate I 2 🗌 No 1 🗌 Yes 25. Was case referred to medical the funeral director. Be 26. Place of Death (Check only one) Hospital 1 Yes 2 X No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending injun after death. 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined 24 hours a Medical 1 🔏 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signa MD D0069300

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

AUG 0 2 2011

Registrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANIANI K KHALID 7141 SECURITY BLVD, BALTIMORE, MD 21244

imothy Larry Red	1-	For State	State	of Maryla		epartmo Certifica		Health and Death	d Menta	l Hyg		eg. No.	201		244	95
Physician Medical Examin	1/ 1	Decedent's Name (First	t, Middle,Last	_	rry			Redd	l		Date of Dear Month July 28, 20	th Day	Year	3	Time of Dear 1930 hrs	th
		a. Facility Name (if not in 1038 Ellicott Driv		street and nun	nber)		4	o. City, Town, or I Baltimore	Location of D				County of I	Death		_
Funeral Director	2	Social Security Number	4 1X	х м 2_F	7. Age (In	yrs. last birt 4	hday) Yrs.	If Under 1 Year Months Days		4Hrs. 8 Min.		th(MM/DI 22			olace (State or try)	
' any	_	Jsual Residence of Dece 0a. State 10b. 0			10c.	City, Town	or Locatio	n							0d. Inside City	
Aaryland 28a-f sbow		MD Oe. Street and Number	NA			Bal	time	ore 10f. Zip Code			11	0g. Citize	en of What		1 X Yes 2	No
th the Maryland 23a or 28a-f sho notified at once		.038 Ellic	ott D						216				U.S.			
er death wi , or items		Marital Status Never Married 2 Widowed 4		12. Was Dece Armed For 1 Yes if Yes, Giva Year			If Ye	Decedent of Hisps, specify Cuban,	Mexican, Pu				4. Race - A White, e	tc.	n Indian, Black	k,
hours a "natura" Examin		15. Decedent's Educatio		l or Dates: ly highest grade College (1-		ed) 16a. I		s Usual Occupationst of working life.				16b. Kir	nd of Busin	ess/ind	lustry	
within 72 iene. Medical	[[6	th grade		na	4 01 0 . 7		Co	ntracto						re	Compa	ny
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur injury or other trannatic event; the Medical Exam		7. Father's Name (First, I arnest rnest Red	đ							res	John	son				
MD 21 d 2 should lith and Me n 27 is ma numatic co	- 1	9a. Informant's Name/Re Delores Gl		•	er	196	. Mailing	Address (Street West Mt	and Number	r or Rura yal	AVE	nber, City Ap t	or Town, 515	State, Z	alto,	217 M
Ore, Pose 1 and of Healt If item		0a. Method of Disposition	_	Removal from	m State	20b. Place o cremato	f Disposit	ion (Name of cem er place)	netery,	D	ate	20c. Lc	ocation - Ci	ty or To	own, State	
Baltimore, permit. Pages I at Department of Her Important: If ite Injury or other tr		Donation 5 Of 1. Signature of Funeral S		see//		King	_	orial F me and Address rch F/H			/2011	Wo	odla	wn,	Ma	
M 립스트를 (Physician \	2	3a. Part I. Enter the disea			A //	eath. Do no	43	00 Waba	ash A	ve,	Balt spiratory arre	imo:	re, k, or heart	Mđ	21215 Approximate I	nterval
/Medical		failure. List only one mmediate Cause (Final d or condition resulting in de	isease a.	Acquire			efic	iency Sy	yndrom	e(AI	DS)				Between Ons Death	
	S	Sequentially list condition	s, b	Oue to (or as a d		2100.										
	E (any, leading to immedia auso. Enter Underlying Disease or injury that init	Causo c.	Oue to (or as a d												
be executed skician and burial - transit		vents resulting in death)	d.	•	·	•		10 0 11	11	* {	3	,				
60, Control of the between the between and bysician and b		UNPENDED FEMALE:	x	AMENDED 2 1 23c. If yes, ou	Z pei	fh g	918	918 8-11 8-16-11	vt	1		23d	Date of de	livery		
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be eithin 24 hours after death. The law requires that the Functor: After this certificate has been signed by the attending physicial pheely filled in by the funeral director, page 2 should be detached for use as the burial confifment on the property of the physicial physi	23	Bb. Was decedent pregna past 12 months?	unt in the	1 Live bir	th nt at time	2		I death 3 [Ectopic pro	egnancy			onth 1	Day	/ Yea	ar
ires that the death signed by the atter I be detached for the detached for the phase in the phas		art il. Other significant	conditions			not resulting	in the un	derlying cause giv	ven in Part I.						e cause of dea	
ords, P. w. requires to as been sign is should be controlled to th										_	24a. Was a	an	24b. Wei	e autor	osy findings av	ailable
of Vital Records, ng Physician: The law require ther this certificate has been si meral director, page 2 should b	nanaidiiion									-	autop: perfor 1 ✓ Yes	med?	dea		npletion of cau 2	
Vital Rec yrician: The his certificate director, page	B 2	5. Was case referred to r examiner?	iHe	ospital: 1 Inc		2 ER/Ou		- 12	of Death (Ch		one)					
ing Physical Company of Marchine The Transfer Company	2	1 ✓ Yes 2 N 7. Manner of Death	lo	28a. Date o			ime of Inj	obox	at Work?		d. Describe h			otner: 5	cene	
Division as or Attendia rs after death. as Director: A led in by the fu		1 X Natural 5 Accident	Pending Investigatio	28e Place	of Injury -	At home, fa	rm. street	1 Ye	es 2 No	-	Location (S	Street and	1 Number o	r Rural	Route Numbe	er City
Division o spital or Attending tours after death. neral Director: After filled in by the fune	֓֞֞֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓		Could not b determined	e (Specify)	,,,,,						or Town, S					., σ.,
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the			ai Examiner:		examinat			d at the time, date n, in my opinion,							ause(s)	
To with To com	25	9b. Signature and title of) ()				29c. License O.C.M		-			ate signed 29, 2011		, Day, Year)	
6	30	0. Name and address of				. ,										
Stat	g 3 ¹	Patricia Aronica-I 1. Date filed (Month, Day,			nt Medic		iner 9	00 W. Baltim	ore Stree	t, Balti	imore, MI	2122	3			
Registra	v	AUG () & 20		And Room		bar	4					-				

DHMH 17 Rev 1/2001 OCME 2006

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend Item 20b per fh g918 8-10-11 vt
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2011

		_	For State Registrar			Certific			TIG WELLER II	Reg. N	001	1.	24496
	Physicia Medic		1. Decedent's Name (First, Middle, La.	Raben	-ts				2. Date of I Month		Day Yes 201		3. Time of Death
	∠ Examin		4a. Facility Name (if not institution, give	street and number)		4b. (City, Town, or	Location of	Death	4	c. County of D	eath	
			2217 Bryant Av	9	0 1 152	it -t-)	Ba Inder 1 Year	ltimo) in a la		Diabolo	Otata an Famian
	Funeral Director		244-10-0/41	ex 7. Age	e (In yrs. last bir 89	Yrs. Mon		Hours	4 Hrs. 8. Date of E Min. (Month, I 09	Day, Year 05	21	Country	nce (State or Foreign
	nd how at	'n	Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Location						10	d. Inside City Limits
	the Maryland or 28a-f show e notified at	Director	MD NA		В	altimo	ore						1X Yes 2 □ No
	the M	٥	10e. Street and Number			101	f. Zip Code			10g.	Citizen of What	Countr	y?
	s 23a	Funeral	2217 Bryant Av	e			_	217			U.S.		
036	permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 Ves 2 If Yes, Give Year or Dates.			ecedent of H specify Cuba es 2 No		n? (Specify Yes or N Puerto Rican, etc.)	0-	14. Race - A Black, W Specify: B	/hite, et	c.
21215-0036	2 hour "natul edical	Be Completed	15. Decedent's E (Specify only highest g		16a	Decedent's	f work done o	ation during most o	of working	16b.	Kind of Busine	ess Indu	ustry
12	ithin 7 ene. • than he Me	Com	Elementary/Seconday (0-12) 5th grade	College (1-4 or 5		erchai	Tuse retired)	am∩n		l se	afare	rs	Union
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Maryland	I be filed fental Hy rked oth tic event	မ	Claxton Robert	3				Ada	Boone				
ary	hould and N is mai		19a. Informant's Name/Relationship (ype, Print)	19	b. Mailing Add	dress (Street	and Number	or Rural Route Num	ber, City	or Town, State	, Zip Co	ode)
	and 2 s Health a em 27 i		Sherry Roberts	-Daughter				ve ls	t Floor				
Baltimore,	Page 1 arment of He lant: If iter		20a. Method of Disposition Marial 2 Cremation 3 C 4 Appropriation 5 Other (Spec	Removal from State	cemete	of Disposition ery, crematory ison	or other plac		9 ^{Date} 5/ 1/ 2011		Location - City		n, State
Balt	permit, Depart Import any inj once,		21. Sign ture of Funeral Service Licer	see RK.	ke	22. Nam	ne and Addre	ss of Facility H Wes	t ve, Bali				1215
			23a. Part 1. Enter the disease, or con	plications that caused	the death. Do	not enter the) Wab mode of dyin	ash A ig, such as c	ve Ba⊥ ardiac or respiratory	arrest,	ore, M		Approximate
	₽hysician/		shock, or heart falure. List only Immediate Cause (Final	one cause on each line	€.							4	Interval Between Onset and Death U2011
	Medical		disease or condition resulting in death)	a. Due to (or as	a consequence	of):						+	1 1
	Examiner	_	Sequentially list conditions	b	PD							i	11/2000
	D #	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence	of):							1.12 200
At	and -trans	Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or as	a consequence	of):						1	142000
P.	icate be executed physician and s the burial-transit	ical		d Chro	mi	tha	~ Hos	m	pain			1	1/2000
3760		Med	IE FEMALE:										
P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending pompleted filled in by the funeral director, page 2 should be detached for use as	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal dea	th 3 🗆 Ecto 5 🗆 Othe	opic pregnan er (specify) _	су		-	23d. Date of Month		y Day Year
P.O.	that th	y Ph	Part II. Other significant conditions			/	ying cause gi	ven in Part I.					e cause of death?
	quires en sign uld be	edt	Peri Vaiente	v du	ile W	ith (J #	K-13-	1	Yes	2 No 3	Prob	ably 4 Unknown
COL	aw rec las be	uple	GERS						24a. W	as an itopsy erformed	prior	r to con	sy findings available apletion of cause of
Re	The l	Co	0A . T.	As					1 □ Ye				2 No
ta	ician: sertifi ector	Be	25. Was case referred to medical examiner?	Hospital:			Oth	er.	(Check only one)				
) \(\sum_{1} \)	Phys this	2	1 Yes 2 No 27. Manne of Death	28a. Date of inju		Time of	28c. Inju	4 L Nur	sing Home 5 Re		6 U Other (S	pecity)	
o u	ding tth. : After e fune	cate	1 Natural 5 Pending 2 Accident Investigation	(Month, Da	y, Year)	injury M	wor	k?]Yes 2□I	No				
Division of Vital Records,	al or Atter s after dea I Director d in by the	Certificate:	3 Suicide 6 Could not 4 Homicide determined	be Diago of Ini		arm, street, fa	actory, office			n (Street Town, Sta	and Number of ate)	r Rural	Route Number,
_	Hospits 24 hour Funera	Medical	(Check 2 Medical Ekar	ysician: To the best of niner: On the basis of e	xamination and	or investigatio	n. in my opini	on, death occ	curred at the time, da	te and pla	ace, and due to	the cau	se(s) and manner stated.
	hthin in the or the or the or the or the	ž	only one) 3 Certifying Nu 29b. Signature and title of certifie	rse Practioner: To the	best of my know	wieage, death	29c. Licens		and place, and due to		Date signed (M		
	777))	MAP	CRACT.	As Dal	RI	3111	3	7	125	12	011
	CA		30. Name and address of person who	completed cause of d	leath (Item 23a)	(Type, Print)			705	J.	Hol	D-	- # G
	(Y)		Augusting Op. 31. Date filed (Month, Day, Year)	cent-of		P.CR	M.M	LN	Lin	the	um	r	m 21090
	Sta Registr		AUG 0 2 2011	Anua 1	ar's Signature	Kel							

Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Day Year Rhodes William 7:15 P 54 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Northwest Seasons Hospice Randallstown Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign 8 Date of Birth **Funeral** Hours 0. Month, 06 - 0 VA 215-46-5739 64 Director Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location or items 23a or 28a-f shominer must be notified at 10a State 10d Inside City Limits filed within 72 hours after death with the Maryland Director MD NA Baltimore XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 301 McMechen Street 21217 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Examiner Black, White, etc. African 1 Never Married 2 ☐ Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates American "natural", 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working nd Mental Hygiene. marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) other traumatic event, the Various jobs 12th Grade 2vrs. Laborer Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William Rhodes, Sr. Marv Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ValJean Gilmore-Sister Rosland Court Pikesville, Maryland 31 20a. Method of Disposition
1 □ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 08-05-11 Catonsville, MD Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wylie Funeral Home P.A. 21. Signature of Funeral Service Licensee 638 N. Gilmor Street Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Liver Cancer disease or condition * Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events Due to (or as a consequence of) -transit the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last physician a s the burial-t Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy 1 ☐ Live Birth 4 ☐ Pregnant 9 ☐ Unknown in the past 12 months? Month Day Year Pregnant at time of death 2 No the g Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed within 24 hours after death.

To the Funeral Director: After this certificate h
completed filled in by the funeral director, page 2 No 1 🗌 Yes Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 other specificent hospice 1 ☐ Yes 2 ☑ No |요 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 \square Yes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) NSRNapannem.D 00057465 8/1/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21209 MD 5-203 Baltimore

State Registrar

31. Date filed (Month, Day, Year) **AUG 0 2 2011**

NS

Rajapaxse, N.D. 2835 Smith egistrar's Signatur

DHMH 17 Rev 1/2001

Registrar

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygienes 1

			1 - For State Registrar	Cer	tificate of Death)	Reg. No.	11 24499
	Physicia	ın/	Decedent's Name (First, Middle, Last)	D		2. Date of D Month		3. Time of Death Year
ر ځيږ	Medic	cal	Marvin Thoma. 4a. Facility Name (if not institution, give street and number)	s Korrer		July	30, 2011	12:15 P ^M
	Examin	ier	2514 Ryce Drive		4b. City, Town, or Locatio Waldorf	n of Death	4c. County	of Death arles
	Funeral Director			(In yrs. last birthday) 90 Yrs.		er 24 Hrs. 8. Date of B Min. (Month, D Jan 22	irth	Birthplace (State or Foreign Country) Virginia
	nd how at	٦	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc	cation			10d. Inside City Limits
	larylar 8a-f sl ified	ecto	Maryland Charles	Waldo				1 🗆 Yes 2 🔯 No
	the M	قَ	10e. Street and Number	WALCO.	10f. Zip Code		10g. Citizen of W	/hat Country?
	n with	Funeral Director	2514 Ryce Drive		20601		United St	rates
	r item iner n	/ Fu	11. Marital Status 12. Was Decedent Ender Armed Forces?		Was Decedent of Hispanic (f Yes, specify Cuban, Mexic	Origin? (Specify Yes or No can, Puerto Rican, etc.)		e - American Indian, k, White, etc.
99	be filed within 72 hours after death with the Maryland antal Hygiene. ked other than "natural", or items 23a or 28a-f sho c event, the Medical Examiner must be notified at	Completed by	1 ☐ Never Married 2 【X Married 1 【V Yes 2 ☐ 1 3 ☐ Widowed 4 ☐ Divorced Year or Dates.	WII	Yes 2 X No Speci	fy:	Specify:	White
2-0	2 hour "natur dical	plete	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	lent's Usual Occupation	ost of working	16b. Kind of Bu	siness Industry
121	thin 72 ane. than be Me	mo.	Elementary/Seconday (0-12) College (1-4 or 5-	ife. D	NOT use retired)	ost of working	A = E	
2	ed wil Hygie other ent, th	Be (12 4	[1		ther's Name (First, Middle	Airfor	
<u>ılan</u>	d be fil dental irked trc ev	မ	Arthur R. Rorrer			Lucy May Neil		,
lan	d 2 should lath and Me 27 is mark		19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street and Num	ber or Rural Route Numb	er, City or Town, St	ate, Zip Code)
<u>ა</u>	and 2 Health em 27 ther tr		Kathleen Rorrer (Wife)		2514 Ryce Drive,	· · · · · · · · · · · · · · · · · · ·		
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State		natory or other place)	Date	1	City or Town, State
Ē	nit. Peartme ortan injun		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee ↑		National Cemet Name and Address of Fac		Arlington	
ä	permi Depar Impor any ir		Dessica (mor	De l	Ferry Road, Cl	THE LUMERAL	.Hame,Inc 6 5	633 Old Alexandria
			23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line.	the death. Do not ente	er the mode of dying, such a	as cardiac or respiratory a	arrest,	Approximate Interval Between
المع	thy vician!		Immediate Cause (Final disease or condition	- boal	Vascul	ac Acc	ident	Onset and Death
	Medical Examiner		resulting in death) Due to (or as a	consequence of):				
		ner		consequence of):				
	uted id ansit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events c					
	e exec ian ar urial-tr	E E		consequence of):				¥
8760	tificate be executed ng physician and as the burial-transit	Medical	d					
89	= 5,0		IF FEMALE: 23c. If yes, outcome c	of <u>pr</u> egnancy			23d Date	e of delivery
Records, P.O. Box	death cert	Physician/	in the past 12 months?	Fetal death 3 time of death 5	Ectopic pregnancy Other (specify)		Mon	· ·
0	t the c by the	Phys	9 Unknown					
ν. σ.	v requires that the de been signed by the should be detached	by	Part II. Other significant conditions contributing to death bu	it not resulting in the u	nderlying cause given in Pa	200. 5.4		bute to the cause of death? 3 Probably 4 Unknown
ğ	requir been should	Completed				24a. Was		Vere autopsy findings available
ပ္ပ	e has	dmo				auto	opsy pr formed? de	rior to completion of cause of eath?
a E	Physician: The law this certificate has ral director, page 2 a	Be C	25. Was case referred to medical		26. Place of D	1 ☐ Yes eath (Check only one)	2 7 No 1	Yes 2 No
=======================================	hysici nis cer I direc	To B		nt 2 🗆 ER/Outpatier	t 3 🗆 ĐOA Other: 4 🗆	Nursing Home 5 PRes	sidence 6 🗌 Other	r (Specify)
Division of Vital	ling Pl		27. Manner of Deat 28a. Date of injury (Month, Day,	Year) 28b. Time of injury	28c. Injury at work?		how injury occurred	d
Sior	al or Attending P s after death. I Director: After t d in by the funera	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 28e Place of Injur	y - At home, farm, stre	M 1 Yes 2		(Street and Niumber	r or Rural Route Number,
Š	al or A s after I Direct		4 Homicide determined 286. Place of injur		ot, lastery, office		wn, State)	or narai noute ivallibei,
_	To the Hospital or Attending Physician: The law requires that the death cerwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendition completed filled in by the funeral director, page 2 should be detached for use	Medical	29a. Certifier 1 Certifying Physician: To the best of n	ny knowledge, death o	occured at the time, date an	d place, and due to the c	ause(s) and manner	r as stated.
	the H thin 24 the Fi	Me	(Check 2 Wedical Examiner: On the basis of ex only one) 3 Certifying Nurse Practioner: To the basis of experiences Control of the basis Control of the basis Control	est of my knowledge, o	leath occurred at the time, da	ate and place, and due to t	he cause(s) and mar	nner as stated.
-	To vit		29b. Signature and title of certifier		29c. License number		29d. Date signed	(Month, Day, Year)
Į	7		30. Name and address of person who completed cause of de	ath (Item 23a) (Type P	D28.	217	5-1	
54	\ \		PO BOX 17	0 3	CoP10,	ta r	of ar	646
	Stat	te	31. Date filed (Month, Day, Year) 32. Registrar	's Stanture	1			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death ecedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 2 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FRANKLIN Square Hospital odal + cTimor e Social Security Number If Under 24 Hrs If Under 1 Year Funeral 7. Age (In yrt. last birthday) 8, Date of Birth 9. Birthplace (State or Foreign 1 M 2 **Director** 28a-f shov 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho. : If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director Rosedale Baltimore 1 Yes 2 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? McCormick Ave. 21206 Funeral ISA 11. Marital Status . Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married 1 Yes 2 No
If Yes, Give
Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: Black and Mental Hygiene, is marked other than "natural"; Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) osmetologist *Be*aut Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Roberson lemino 19a. Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Rural Route Numb Riley husbana 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Arbutus Mem. PK 4 ☐ Donation 5 ☐ Other (Specify)

Division of Vital Records, P.O. Box 68760

Carolyn

Rile

	21. Signature of Funeral Service Labor	GO	ary P. March F/H	270 Fredhilter Balto. MD 2	
	23a. PM F ter the disease, or con shotk or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. 3 reast Canc Due to (or as a consequence of):	er with me	etastatic	Approximate Interval Betwe Onset and Dea
ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	b. Maligant Due to (or as a consequence of): c. Due to (or as a consequence of):	leural effus	sion	wee
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 4 Pregnant at time of death 5 Unknown	Ectopic pregnancy Other (specify)	23d. Date of Month	delivery Day Year
þ	Part II. Other significant conditions	contributing to death but not resulting in the ur	nderlying cause given in Part I.	23e. Did tobacco use contribute 1 Yes 2 No 3	_
Completed				autopsy prior performed? death	autopsy findings avai to completion of caus ? Yes 2 \(\sum \) No
To Be (25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient	26. Place of Death (Check		necify)
Certificate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year) 28b. Time of injury		28d. Describe how injury occurred	
	3 Suicide 6 Could not 4 Homicide determined		et, factory, office	28f. Location (Street and Number or City or Town, State)	Rural Route Number,
Medical	Check 2 ☐ Medical Exam	sician: To the best of my knowledge, death or niner: On the basis of examination and/or investingse Practioner: To the best of my knowledge, do	gation, in my opinion, death occurred at	the time date and place, and due to the	ne cause(s) and manner
	29b. Signature and title of certifier	my	29c. License number 0 5 4 7 3 6	29d. Date signed (Mo	nth, Day, Year)
	DR Kamlun/R	completed cause of death (lem 23a) (Type, Pr A		are DR Balto	md 212
ite rar	31. Date filed (Month, Day, Gar) AUG 0 2	2011 32. Figistráis Signature	all		